**Gastroenterology Consultants to South Jersey, P.C.**

**Credit Card Policy**

As of April 8, 2014 Gastroenterology Consultants of South Jersey implemented a new office policy of obtaining a credit card number for all of our patients. We are doing this in order to process charges for balances owed **after insurance claims are fully processed and completed.** There are several reasons why we have found it necessary to implement this policy. First, as the healthcare market is changing, most insurance plans have higher and higher deductibles and co-payments. In order to continue to provide you the level of care and service you have come to expect from us, we depend on prompt collection of these deductibles and co-payments. Processing these charges via a credit card number on file ensures prompt payment for services provided once claims are complete without need to collect fees in advance. Secondly, we have found that many of the outstanding balances are often small. The cost of trying to collect these balances via sending statements and making phone calls is rising. Payment for these balances via a credit card on file will prevent us from incurring these unreasonable additional cost.

Here is what you can expect:

1. **After your insurance claim is processed and completed**, your balance due for service will be charged to the credit card we have on file. This will occur automatically, and you will be sent a statement indicating that the payment has been processed and that the balance due has been cleared.
2. This policy in no way affects your ability to contest coverage for services with your insurance company. If we subsequently obtain payment for charges after your claim is reprocessed by your insurance, you will be refunded that amount.

For those patients who do not want to leave a credit card number with us for whatever reason, we ask that you pay $100 up front, which will be credited to your account and used to pay balances as they become due.

Thank you for your understanding and cooperation with this policy.

**Authorization:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (month, day, year: xx/xx/xxxx)

Credit Card Type or HAS/FSA card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (month, year: xx/xxxx)

V-Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_