



### **Auto Payment Financial Policy**

To better serve our patients, we understand the need for clear communication of our financial policies. Please understand that payment for service is an important part of our professional relationship and we strive to be good stewards of your healthcare dollars.

**Prior to receiving products we require a form of payment on file to satisfy any balances that are the responsibility of the patient.**

If you have provided insurance coverage to us, we will first bill your insurance company with the necessary information. The balance remaining after insurance has been applied is your responsibility, including insurance deductible amounts. Our office will send an invoice to you once your patient balance is determined. The credit card or bank account listed below will be charged on the due date specified on your next invoice. We will notify you by email, 7 days in advance, before any charges will be applied.

We accept *Visa, MasterCard, Discover, American Express, Health Saving Accounts, Care Credit and Bank Debt cards*. All payment account information will remain confidential and securely stored by our PCI compliant merchant processor.

**CC#** \_\_\_\_\_ **EXP** \_\_\_\_\_ **CVV** \_\_\_\_\_

### **Payment Authorization for Automatic Payment**

I hereby authorize Fairway Medical to charge the payment method I have provided for any balances that are the responsibility of the patient.

PATIENT NAME: \_\_\_\_\_

(Print Name)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_