Reflect Medical & Cosmetic Center, LLC

Pre-Authorized Healthcare Credit Card Form

By signing below, I agree to all of Reflect Medical & Cosmetic Center Credit Card on File Policy and I authorize Advanced Medical & Cosmetic Center to keep my signature and a valid credit/debit card number securely on-file in my account. I allow Advanced Medical & Cosmetic Center to automatically charge my credit card for any outstanding balances. These may include: insurance denials for ANY reason (including no referral on file); missed or cancelled appointments; deductibles; co-insurances; partially paid claims. Missed or cancelled appointments without 24-hour notice will be charged missed appointment fee at the time of the appointment.

If the credit card we have on file for you changes, please notify your clinicians IMMEDIATELY by phone or email. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days. We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.

I understand that I am responsible for payment for all medical services provided to me by Advanced Medical & Cosmetic Center. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow Advanced Medical & Advanced Medical Cosmetic Center to immediately charge my credit card on file for remaining balance. I understand that this form is valid until I cancel this authorization through written notice to Advanced Medical & Cosmetic Center.

I (we), the undersigned, authorize and request that Advanced Medical & Cosmetic Center charge my credit card for the balance due that my health plan identifies as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me by Advanced Medical & Cosmetic Center. My card will remain securely stored for future use by Advanced Medical & Medical Center for payment of balances due from me. This authorization will remain in effect until revoked by me in writing.

Patient's account # _____ Patient's name: _____

☐ Please keep my credit card on file and charge my account to pay for charges not paid by my insurance plan.

Charge my card on the following day of the month (or the nearest business day prior to the day selected):

☐ 7th

☐ 28th

Patient/Guardian signature _____ Date_____

Credit Card Information:

Card type: ☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Card # _____ Exp. Date (Mo/Year) ___ / ___

(Reminder to Staff --Destroy number after entering to secure site)

Is this a Flexible Spending/Health Savings card? ☐ Yes ☐ No

Name as shown on Card (print) _____

Card's Bill To Street Address _____

City _____State_____ Zip _____ Contact phone: _____

Email receipt to _____@_____ OR ☐ Mail receipt

For office use only:

Authorization received by: _____ Office location: _____