OAKVIEW
DERMATOLOGY

Autopay Agreement

Oakview Dermatology has implemented a new credit card policy in order to provide the best patient care while ensuring a simple and cost-effective billing process. Similar to other businesses in various industries, such as hotels, car rental agencies, and attorneys, we now request a credit card to have on file, which may be used to settle any outstanding balance on your bill.

Having a credit card on file that allows patients to autopay is a growing trend in the healthcare industry, driven by the implementation of the Affordable Care Act and Health Exchanges. With higher deductibles, coinsurance, and copays, patients are increasingly responsible for a larger portion of their healthcare expenses, even if they have insurance coverage.

During the check-in process, we will securely collect your credit card information, which will be stored until your insurance provider(s) has paid their portion and we are notified of any remaining balance. Rest assured that we do not retain credit card information at our office. It is stored securely on a Health Insurance Portability and Accountability Act (HIPAA) compliant Payment Card Industry - Data Security Standard (PCI-DSS) server. Please note that copays are still expected to be paid at the time of service.

The introduction of this Autopay Agreement does not impact your ability to dispute charges or question your insurance company's determination of payment. This Agreement solely pertains to settling outstanding account balances after insurance adjudication. We will continue to bill your insurance company on your behalf.

By signing below, I authorize Oakview Dermatology to securely retain my signature and credit card information in my account. I grant Oakview Dermatology permission to charge my credit card up to $1000.00 for any current outstanding balances and any future balances that may arise. I understand that I am responsible for any remaining amount due after Oakview Dermatology charges my card, or if Oakview Dermatology cannot charge my card for any reason. I acknowledge that the maximum amount charged to my credit card may change upon at least 10 days' notice from Oakview Dermatology. If the credit card I provide today undergoes any changes, expiration, or is denied for any reason, I agree to promptly provide Oakview Dermatology with a new, valid credit card and authorize them to process the new card over the telephone. I understand that the new card will be used with the same authorization as the original card I presented. I acknowledge that I may revoke this authorization at any time by written notice to Oakview Dermatology. Please allow up to 5 business days for such revocation to take effect.

If you have any questions or concerns regarding this Autopay Agreement, please feel free to inquire at 740-566-4621

_____Visa _____MasterCard _____Discover _____American Express

Patient's Name (Print): _____ DOB: ___/___/_____

Name on Card (Print): _____

Credit Card Number (last four digits): _____ Exp. Date: ____/_____

Email Address: _____

Please fill out information below for any other person(s) you authorize this credit card for (other family members who also have accounts with Oakview Dermatology):

Patient Full Name (Print): _____ DOB: __/___/_____
Patient Full Name (Print): _____ DOB: __/___/_____
Patient Full Name (Print): _____ DOB:__/___/_____

Credit Card Holder's Signature: _____ **Date**: _____