Credit Card Authorization Form for Medical Services

Routine eye wellness exams will be billed to your vision insurance plan and patient responsibility for routine exam or materials copays and coinsurance is due at the time of visit. However, if you present with a medical complaint, have medical testing, or the doctor uncovers a medical diagnosis as the cause of your presenting symptoms, then the exam and/or any associated medical procedures must be billed to your medical insurance carrier. We will bill your medical insurance as a courtesy, but you will be responsible for any copays, co-insurance, or unmet deductible that your insurance company deems your responsibility.

At Ascent Eye Care & Eyewear Gallery, it is our policy that a credit card be kept on file prior to any medical services being rendered. Your credit card information is kept confidential and stored in a secure electronic portal (Chase Paymentech). Your credit card will not be charged until after the claim has been filed and processed by your medical insurer carrier. Once we have received an explanation of payment from your carrier, we will give you a 48 hour courtesy call notifying you of any patient responsibility. The credit card you have on file will then be charged for that amount

Again, payments to your card are processed only after the claim has been filed and processed by your insurer. You will be notified 48 hours prior to the credit card charge being posted, and will have the opportunity to make alternative payment arrangements if need be.

If you choose not to keep your credit card information on file, payment for all medical services rendered will be due in full at the time of service.

Credit Card Information:

Cardholder Name _____

Type of Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER

Last 4 Digits of Credit Card Number_____

Expiration Date_____/_____

Card Billing Address: _____

I hereby authorize my credit card to be charged for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Ascent Eye Care & Eyewear Gallery, PLLC. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Ascent Eye Care & Eyewear Gallery, PLLC in writing and the account must be in good standing.

Patient name (print): _____

Signature: _____

Date: _____