Short Hills ophthalmology

Michael Farbowitz, MD Michael Mund, MD
Andrea Antonelli, OD Diann Brophy, OD
551 Millburn Avenue, Short Hills, NJ 07078 T 973.379.2544
1187 Main Avenue, Suite1F, Clifton, NJ 07011 T 973.546.6161

Credit Card on File Authorization Form

At Short Hills Ophthalmology, we require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance company doesn't cover, but for which you are liable. (PLEASE SEE CREDIT CARD ON FILE POLICY FOR FULL DETAILS.) Initial_____

Your credit card information is kept confidential and electronically secure at KEY BANK. Charges to your credit card are made only after the claim has been filed and processed by your insurer and the insurance portions of the claim has been paid, adjusted, and posted to your account.

I, the undersigned, authorize Short Hills Ophthalmology Group to charge the portion of my bill that is my financial responsibility as per the insurance company EOB to the following credit card. Balances $5 or less will be charged immediately, otherwise I will receive a statement from Short Hills Ophthalmology for the balance my ins company determines I owe. If you receive a "no-show" fee of $25 for not canceling or rescheduling your appointment within 24 hours, this charge will automatically be charged to your credit card on file. I understand that my credit card will be charged 30 days after statement date if other arrangements have not been made. I will receive a receipt via email only. A one-time charge of one cent (.01) will be charged, and I will be reimbursed in cash at time of swipe. I agree to notify and update my credit card as necessary. A $35 fee will be added to my account if my credit card declines. This authorization will remain in effect until I cancel it. To cancel, I must give a 60-day notification to Short Hills Ophthalmology in writing and the account must be in good standing.

___AMEX ___VISA ___MasterCard ___Discover ___CareCredit

LAST 4 DIGITS Credit Card# _____ Expiration_____/_____

PATIENT Name _____

Cardholder Name _____

Signature _____

Billing Address _____

Email Address _____

Signature _____ **Date**_____