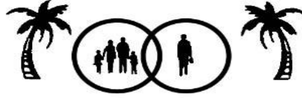

Primary Care of the Treasure Coast, Inc.

1265 36th Street
Vero Beach, Florida 32960
Phone (772) 567-6340 Fax (772) 567-3564
www.familymds.net

Please read in entirety

in addition, feel free to ask any questions of our staff

Primary Care of the Treasure Coast, in an attempt to better serve you and reduce costs that could be passed on to you, has implemented a new policy. This new policy has gone into effect for the entire practice and your participation is required. Patients who refuse to comply with this policy will be asked to leave the practice. Under our new policy, we will keep credit or debit card information on file for all patients. It will be used to cover any charges not paid by insurance. Patients will still be expected to pay known co-pays, co-insurance, and applicable deductibles at the time of service. If a balance remains after insurance has paid, you will receive one statement for the services and after 30 days, any amount left on your account after insurance has been processed will be placed on your credit/debit card. (It will be the responsibility of the patient to contact our office if there is any question regarding the claim or amount due). All of our employees are bonded and as added security, your information is kept separate from your medical chart. We ask that you complete the form below that will give all the necessary information. The information we acquire will be kept securely and will only be used for your medical expenses.
Your understanding and patience with this new policy is important. We are confident that once you begin working with this policy, you will find it is much easier to keep track of your medical expenses and gives you an opportunity to get proof of your coverage from your insurance company (by way of an explanation of benefits) before you are charged. No charges will be placed on your card until after we hear from your insurance carrier.

Today's Date: ________________

Please circle card type: ***Visa / MC / AMEX / DISC*** ***Expiration date***____________________

Card Number ____________-____________-____________-____________

Patient(s) name: **«FirstName» «MiddleInitial» «LastName»**

Additional names to add to this card: ____

Address to which credit card is billed: ____

Name of card holder ***(if not patient) and relation to patient:*** ____

X ____

Signature of Cardholder as it appears on card

Account Number: **«PatientAcccountNumer»** *Physician:* **«PcpLName»**

******Primary Care will not call any patient prior to applying charges to a credit card after a statement has been sent and 30 days have passed.***
Any contact regarding charges or disputes will be the responsibility of the patient.***

Credit/Debit card Consent Form

I authorize Primary Care of the Treasure Coast, Inc. to maintain my credit/debit card information for payment if any balance not paid by my insurance as agreed below. I assign my insurance benefits to the provider listed above authorizing payment by my insurance company to Primary Care of the Treasure Coast. I authorize Primary Care of the Treasure Coast, Inc. to apply the balance of my account to the credit/debit card listed below to include co-pays, deductibles, and any balance that might remain after my insurance has been processed. I understand that this form is valid until I provide written notice that it is revoked (after all balances are paid in full.) I also understand that if I change charge cards, I will supply Primary Care of the Treasure Coast, Inc the new credit/debit card information.