Goldberg Podiatry Center, LLC

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22 Old Short Hills Road Suite 214
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Date:_____ Patient Acct#_____

Auth. Received by: _____

Credit Card on File Agreement- Effective August 12th, 2024

Goldberg Podiatry Center, LLC/ Dr Karyn L Goldberg has implemented a new credit card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed "patient's responsibility", such as co-pays, deductibles and co-insurances.

Co-pays/ balances are still due at the time of visit. Upon check-in, the patient's credit card information will be obtained and thus kept confidential, secure and encrypted. Once the insurance companies have paid their portion, they will notify Goldberg Podiatry Center of the balance due, if any. At that time, our billing manager will issue one statement via regular mail after which the patient will have 14 days to pay the balance or make other payment arrangements. After 14 days, the credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the billing manager will notify the patient. The patient will have an additional 14 days to arrange payment before the bill is subject to additional collection activity.

If you have any questions about our policy, please ask to speak to our office manager Carolina

I authorize Goldberg Podiatry Center to keep my credit card safely encrypted on file and to charge my card for any outstanding balances that my health plan has identified as my financial responsibility.

If the provided credit card has changed, expired, or been denies for any reason, I agree to immediately give Goldberg Podiatry Center a new, valid credit card which I allow to be charged on the phone. I agree that the new credit card will be used with the same authorization as the original credit card I presented.

☐ **Please let check this box if you prefer not to receive a statement & would like us to bill your debit/credit card immediately for any balances due after processing of your insurance.**

Visa	Mastercard	American Express	Discover
Patient's Name: (Print)		Date of birth: (mm/dd/yyyy)	
Cardholder's Name (Print):			
Credit/Debit card number		Exp. Date	
Card Billing Address:			

Credit Card Holder's Signature: _____ Date: _____