INSURANCE EXPRESS CHECK OUT FORM

Patient Name:_____ Date:_____

VIP EXPRESS CHECKOUT

Our VIP express Checkout Program allows us to continue to offer you the convenience of using your insurance plan as a form of direct payment. Please complete the information below. It will be kept confidential and used only under the agreed terms.

I agree to the FINANCIAL RESPONSIBILITY for the following:

The Out of Pocket Portion and Balance not covered by Insurance.
I _____authorize Dr. _____ to keep my signature on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion has been received. I will be notified by phone or mail if any charge or credit is in excess of $100.00.

I give my permission for any claim not paid by my insurance company within 90 days, to be automatically put through on my credit card. A receipt for this transaction will be mailed with a paid statement.

Signature:_____ Date:_____

Payment by: ___Visa ___Mastercard

I do not have a credit card, but I have permission for you to use a family member or spouse's card. Relationship to this person:_____
Their phone #_____