Credit Card on File Billing Authorization Form

At Home Medical Providers are offering a secure and convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been filed to and processed by your insurance carrier, and the insurance portion of the claim has posted to your account, or in the event that valid insurance information was not provided at the time of service.

I, ____ , authorize At Home Medical Providers to capture my credit card information and securely store my credit card on file.

I, ____, authorize At Home Medical Providers to charge my credit card on file for any balance owing on the below indicated account up to $ ________________ (we recommend entering your deductible amount) per month.

I agree that At Home Medical Providers may charge my credit card on file for the balance due when they receive a copy of the EOB. This authorization relates to all balances not covered by my insurance company for services provided by At Home Medical Providers. This could be amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization to At Home Medical Providers. Written notice must be submitted to At Home Medical Providers, P O Box 1259 Meridian, ID 83680.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

______________________________________ ____

Cardholder Signature Date