River Bend
Family Medicine

River Bend Family Medicine can keep your credit card information securely, and make your payments for you. You won't need to wait at our check-in while we process your co-pay, nor will you need to bother with billing statements and checks. Payments to your card are processed only after the claim has been filed and processed by your insurer.

We may REQUIRE this information if you have an account balance that is being paid in installments.

We can email your receipt to you along with the billing statement we've paid for you, or keep them at the office until you pick them up.

I authorize River Bend Family Medicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Maximum amount to be billed $________ Date of month you'd prefer to be billed? ___

If making monthly payments on a balance, how much per month do you want to pay until your balance is paid off? $__________

Credit Card Number ____

Expiration Date _____ / _____ / _____

Cardholder Name ____

Signature ____

Billing Address ____

City ______________________ **State**_______ **Zip** ___________

Email address ______________________________

I (we), the undersigned, authorize and request [practice name] to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by River Bend Family Medicine

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to River Bend Family Medicine in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ____

Date: _____ / _____ / _____