River Bend Family Medicine

River Bend Family Medicine can keep your bank account 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 account 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.

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? $_____

You may use this method of payment for others. Please list them here: _____

_____(use back if necessary)

I authorize River Bend Family Medicine to charge the portion of my bill that is my financial responsibility to the following bank account:

Routing Number _____

Account # _____

Type of Account: **Checking** **Savings** **Other**

Account 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: _____ / _____ / _____