COMPASS URGENT CARE®

Depending on your insurance plan, there may be a portion of today's visit that is not covered. This unpaid portion will be your responsibility. Compass Urgent Care requires authorization to bill your credit or debit card for any unpaid portion of your visit. Within 30 days of your office visit, you will receive an email detailing what was paid by your insurance and what the remaining balance is on your account. The remaining balance is your responsibility. You will have 10 days from the date of the email to pay in full using cash, check, or credit card. Should payment arrangements not be made within those 10 days, your credit/debit card will be charged for the remaining balance on your account.

Compass Urgent Care requires a credit or debit card to cover any portion of your visit not covered by your insurance. Your credit/debit card information will not be stored on our computers, but will be held for 90 days by First Data – the largest credit card processor in the world.

You will be asked to sign this authorization and provide a credit/debit card at every visit.

Thank you for choosing Compass Urgent Care to guide you on your path to better health!

Credit Card/Debit Card Authorization

Compass Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of the explanation of benefits from your insurance carrier, any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data.** Compass Urgent Care will not store any banking account data.

I hereby authorize Compass Urgent Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card 10 days after the email is sent. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

Valid Email: _____

_____ _____

Patient Name / Cardholder Signature Date