NORTHEAST TEXAS NEUROLOGY ASSOCIATES

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Credit Card on File Policy

Northeast Texas Neurology Associates (NETNA) requires a credit card on file to make the billing process simple and easy for the clinic and our patients.

Your credit card information is stored within our secure electronic health record, which meets the strict HIPAA security standards. **We swipe your card into the system, and only the last 4 digits of the card are visible to any staff at NETNA. We do not write down nor keep any written information about your card including the number, expiration date or security code on the back of the card. Do not put any of that information on this form.**

For any balances owed after a visit or procedure, we will send you a statement in the mail. Within 28 days, if we have not received payment, we will send you an email notifying you that your card on file will be charged. If you wish to settle your balance by another payment method, please contact our office within those 28 days. We will send you a receipt after your card has been charged.

If your card is declined, we will contact you via phone. Your account becomes delinquent if not paid within 30 days after the date of the original statement. Further delinquency will be subject to collection. NETNA reserves the right to terminate a patient from the practice if payment is not received according to the agreed upon payment arrangements.

We understand that healthcare is often a large expense, and we are always willing to provide payment arrangements. These arrangements will require a credit card on file for monthly payments. Please contact our billing department if you need assistance with paying your outstanding balance.

By signing below, you acknowledge and agree to the NETNA's Credit Card on File policy. **AGREEMENT AND SIGNATURE BELOW IS REQUIRED OF ALL PATIENTS SEEN AT OUR CLINIC, EVEN IF YOU DO NOT HAVE A CREDIT CARD.** If the patient is not able to sign, the signer below is the legal guardian or responsible for the patient's account.

_____ _____

Name on Credit Card | Relation to Patient (Self, Guardian, etc)

_____ _____

Signature | Date