



Credit Card Policy

At Anew Life Prosthetics and Orthotics, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance may or may not cover, but for which you may be liable. **Without this authorization, a billing fee of \$25.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charged for each month that the bill remains unpaid.**

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Anew Life Prosthetics and Orthotics, to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Amex Visa Mastercard Discover Credit

Card Number _____

Expiration Date ____ / ____ / ____

Cardholder Name _____

Billing Address _____

City _____ State _____ Zip _____

I (we), the undersigned, authorize and request Anew Life Prosthetics and Orthotics, 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 Anew Life Prosthetics and Orthotics. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Anew Life Prosthetics and Orthotics in writing and the account must be in good standing.

Patient Signature: _____ Date: ____ - ____ - ____

Revised Date 03-01-2019