Genesis Therapy Center
6006 W. 159th Street, Bldg C
Oak Forest, IL 60452
708-535-7320

CREDIT CARD INFORMATION RETENTION POLICY

Thank you for providing us with your insurance information. Claims for your services will be filed promptly and payments will be applied to charges for today's services. You may have noticed that the changing healthcare market has created an increase of financial responsibility being shifted to the patient. This has resulted in patient balances, high deductibles, uncovered services, increased co-pays and co-insurances. For this reason, we, as many other practices, are adopting new financial policies that will create more efficient and convenient resolution of patient balances.

As a convenience to our patients, we ask that you provide us with your credit card information. This information will be kept in a confidential and secure file. We are committed to following the strict rules and guidelines established by HIPAA to insure your privacy is protected and we maintain strict standards to safeguard your credit card information as required under the Payment Card Industry Data Security Standard (PCI DSS). This convenient protocol will allow you to pay for the portions of your services that are not covered by your insurance plan in an easy and secure manner. In the case of overpayments, refunds will also be processed automatically. Charges for your visit will be submitted to your insurance company and if there is a patient balance due, you will be notified by e-mail or phone of the credit card transaction.

Please complete the following:

Patient Name:_____ Date of Birth:_____

Account guarantor (if other than patient):_____

__ I authorize The Genesis Therapy Center to keep my credit card on file with the understanding that charges will be processed for charges not paid by my insurance. The credit card will be used as a convenience to pay for balances as determined by my insurance company. Charges less than $200 will be processed automatically. Patient accounts higher than $200 will require a verbal authorization.

Signature_____ Date_____

CREDIT CARD INFORMATION: Credit card type: __ VISA __ MasterCard

Card #_____ Exp. Date_____ CSV Code_____

Name as shown on card _____

Bill to address _____

_____Zip Code _____

Contact Phone #_____E-mail address_____

PLEASE NOTE: If your credit card information is not on file, there will be a billing fee of $5.00 added to your account every time a statement is mailed to you.