27 Hilliard St, Manchester, CT 06042

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Easy Pay Agreement

Frank J Bush, MD, PC requires that a valid credit card/HSA card be kept on file.

The policy is designed to:

- Help avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts
- Focus our time and energy on your children and their medical care

The card information is stored electronically in an encrypted form and **cannot be viewed by our office staff.** Your signature will authorize the card to be used **only** when your balance becomes past due (30 days from statement date).

How the policy works:

1. At the time of your registration or check-in, you will be asked for your credit card information. All cards are being securely stored in a PCI Compliant and Certified platform called CardPointe using Point-to-Point encryption.
2. **Easy Pay can be used for any copays due at the time of service.**
3. We will bill your insurance carrier for all charges related to the visit.
4. When we receive an explanation of benefits (EOB) from your insurance, we will send you a statement. If we have not received payment by 30 days of the statement date, we will charge the credit card on file for the balance due.
5. If we attempt to use your card and it is declined for any reason, we will contact you.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your credit card in error, you may contact our office ASAP. If a mistake has been made, we will reverse the charges.

I have reviewed the Frank J. Bush, MD, PC financial policy and Easy Pay policy. I agree to provide my credit card information to Frank J. Bush, MD, PC for the sole purpose of payment for my child(ren)'s medical care. I have the right to cancel this process and use another form of payment.

____	____
Signature of Authorized User	Date
____	____
Print Name as it appears on your credit card	Phone # of Cardholder
____	
Email address	

Last 4 Digits of credit card: _________________ **Expiration date (MM/YY):** __________ **CVV/security code:** __________

Card Type (circle one): Mastercard Visa Discover American Express

Until further notice, I ____, authorize Frank J Bush, MD, PC to charge the patient responsible balances on my account to the following credit card:

Children's Names & Dates of Birth:
(Card will be used for balances for all patients listed below)

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