



Card on File Agreement - Effective April 1, 2026

Premier Internal Medicine of Alpharetta, PC has implemented a new card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. Cards on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible and co-insurance. This will be valid for **one (1) year** from the date the agreement is signed by the patient. The completed form can be faxed to (866) 292-0442 or emailed to frontdesk@premierinternalmedicineofalpharetta.com or brought to the office.

Copays, co-insurance and partial deductibles are still due at time of visit. At check-in, the card information will be obtained and kept confidential and secure until the insurance(s) has processed the claim and notifies Premier Internal Medicine of Alpharetta, PC of the balance due, if any. At that time, **one statement via mail** will be issued which the patient will have **30 days** to pay the balance or make other payment arrangements. After 30 days, the card on file will be automatically charged for outstanding balance up to the set \$250.00 maximum. The patient will have an additional 30 days to arrange payment before the bill is subject to additional collections activity.

If you have any questions or inquiries regarding the policy, please feel free to contact our office at (678) 369-6993.

I, the patient and/or card holder, authorize Premier Internal Medicine of Alpharetta to keep my card on file and to charge my card for any outstanding balances that my health plan has identified as my financial responsibility.

If the provided card has changed, expired or denied for any reason, I agree to immediately give Premier Internal Medicine of Alpharetta, PC a new, valid card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	<input type="checkbox"/> American Express
Patient's Name (print):			
Date of Birth (mm/dd/yyyy):			
Cardholder Name (print):			
Last Four Digits of Debit/Credit Card Number:		Exp. Date:	
Card Billing Address:			
Please check this box if you prefer <u>not</u> to receive a statement and would like us to bill your card immediately for any balances due after the processing of your insurance.			

Card Holder's Signature: Date:

<u>OFFICE USE</u>		
Authorization Received by:	(Initials)	Date: