Neil S Goldberg, MD

77 Pondfield Road
Bronxville, NY 10708
(914) 337-4499

To Our Patients:

Thank you for allowing us to participate in your healthcare.

As you know the practice of medicine has been changing very rapidly lately and we are now trying to make our office more efficient.

To that end, we have implemented a new policy to eliminate the need to bill patients for co-pays and deductibles.

Many of you have insurance policies with substantial co-pays and large deductibles. Because it is not always possible to calculate these charges in advance, we often must send invoices at a much later date.

This has created a large burden for us and we can no longer afford to wait and bill patients for these payments. Our only other choice would be stop accepting insurance all together, as many of our colleagues already do.

In order to save money and time we are asking for a credit card number at the time you check in. The information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This benefits all of us by keeping the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Fixed, traditional co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

We appreciate your help with this.

Sincerely yours,

Neil S Goldberg, MD

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Healthcare Credit Card Authorization

I authorize **NEIL S GOLDBERG, MD** to keep my signature on file and to

charge my credit card

- ❑ American Express
- ❑ Visa
- ❑ Master Card

Any balances deemed "patient responsibility" or non-covered by my insurance company

This amount is not to exceed $_____.

This will apply to (choose one): ❑ **This visit only** or ❑ **All visits this year.**

I assign my insurance benefits to Neil S Goldberg, MD. I understand that this form is valid for one year unless I cancel the authorization in writing.

Patient Name (please print)_____

Cardholder Name_____

Cardholder Billing Address_____

_____

City, State Zip_____

Card Number_____

Expiration Date (mo/yr) _____

Cardholder Signature_____ **Date** _____