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Credit Card Authorization for balances due to out-of-pocket Expenses

Your health insurance plans may include 'out-of-pocket expenses' which can include, but not limited to, copays, co-insurance, and deductible before any charges are reimbursed. Our office staff works diligently prior, during, and after your appointment to obtain all information from your health insurance plan via all resources your health insurance makes available and via all the electronic tools we can access. However, your health plan's data may not be accurate or available at the time of your appointment. To avoid billing you for 'out-of-pocket' expenses, we require a valid credit card on file.

By your signature below, you authorize Orange County Neurology, Inc. (OCN) to charge the credit card you have listed below for all allowed out-of-pocket or unpaid balances owed for medical services rendered. As per your health insurance agreement, allowed out-of-pocket expenses may include unpaid balances due to copays, co-insurance, deductibles, or any balance due to OCN for all medically-necessary services already rendered.

Please note: Your credit card data along with ALL information submitted to our office (or any other medical office) are **kept strictly confidential** as required by federal and state HIPAA laws. Your information including all financial data is entered into a highly secure electronic medical record (EMR) system and becomes part of your private health information (PHI). Our office uses Allscripts Professional EMR system which is a registered and approved system by both state and federal regulatory agencies.

As a courtesy, our billing staff will notify you via phone call if you have a balance when charging your card for the above expenses. In addition, you will receive detailed invoice with details of all charges in the mail to address on file. All remaining balance on your account are due at time of the notification and will be charged in full. Our office will reimburse any charges that may have accrued in error for any reason or if the charged balance is later paid by your health insurance.

Credit Card Type:

Visa MasterCard American Express Discover Debit

Name: _____

Credit Card No: _____

Credit Card Security Code: _____

Expiration Date: _____

Billing Zip Code: _____

Sign: _____

Date: _____