Kathleen Vine MD PC

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. Co-payment, Deductible, Co-insurance), we are legally required to collect these, no exceptions will be made. You are required to pay your Co-payment at the time of your visit. Any deductible or co-insurance is billed to you after it is processed through insurance.

If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.

If your insurance requires you to meet an annual deductible before your healthcare is covered you will be billed for the services rendered if you have not met your deductible.
You will be asked to leave a credit card number at the time of check-in. This information will be held securely until your insurances have paid their portion and notified us of your share. As a courtesy, you will receive two statements to your billing address and if not paid within those two statements, the card on file will be charged.

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment. You may call our billing office at 718-845-2452.

I _____ (print name) authorize (Kathleen Vine, MD PC)
to charge outstanding balances on my credit card on file.

Card Type: VS __ MC __ AMX __ DSC __ CC #: _____-_____-_____-_____

Exp Date: _____/_____ Security Code: _____
IS THE CARD PROVIDER AN HRA OR FLEX SPENDING ACCOUNT? YES _____ NO _____
Select One:

___ Credit card billing address is the same as the current mailing address.

___ Credit card billing address is different from the current mailing address.
The correct billing address associated with the card provided is:

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

I have read the above carefully and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and (is selected) understand that these charges will be applied to the credit card I have provided.

Signature: _____ Date: _____