

## *Easy Pay Policy*

*Thank you for choosing Ozark Surgical Associates, LLC as your health care provider. We are committed to your treatment being a success. Our Staff will work very hard to make sure your paperwork is filed accurately and promptly.*

*In order to provide you with the highest quality service, while keeping our billing costs low, we have implemented paperless billing through EASY PAY. You will be asked for a credit/debit card number at the time you check in and 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/debit card and a copy of the charge will be mailed to you. If your balance is \$500.00 or higher, we will attempt to notify you prior to charging your account.*

*This is an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everyone in helping to keep down the cost of health care.*

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

*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, our Billing Department will be more than happy to give you more information about EASY PAY.*

## *EASY PAY Consent Form*

*I authorize Ozark Surgical Associates, LLC. to maintain my credit/debit card on file to cover the patient's responsibility. We will credit/debit the designated account for payment in full upon receipt of the Explanation of Benefits.*

*I assign my insurance benefits to Ozark Surgical Associates, LLC.. I understand that this form is valid for one year unless I cancel the authorization through written notice to Ozark Surgical Associates, LLC...*

\_\_\_\_\_  
*Cardholder Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Cardholder Name*

\_\_\_\_\_  
*Cardholder Address*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Zip*

*Credit*

*Debit*

\_\_\_\_\_  
*Card Number*

\_\_\_\_\_  
*Expiration Date*

/

\_\_\_\_\_  
*V Code*

*Copy front and back of credit/debit card below:*