

Albert J. Nemeth M.D., F.A.A.D., F.A.S.L.M.S., F.A.S.D.S., F.I.S.H.R.S.

ADVANCED SPECIALIZED LASER CENTER™

Tel (727) 799-5273 Fax (727) 791-9325

Albert J. Nemeth, M.D.  
3165 North McMullen Booth Road  
Building C, Suite 2  
Clearwater, Florida 33761

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. If we are providers for your insurance company, you will be asked for a credit 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 your financial responsibility. At that time, any remaining balance due Dr. Nemeth will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: you will pay in full at the time of your visit, we will file your medical claim to your insurance company as a courtesy, and after receiving an Explanation of Benefits (EOB) from your insurance company, any credits will be refunded to you by your insurance plan or our office. **It is in your best interest to understand your insurance plan.**

This credit card policy will be an advantage to you as you will no longer have to prepare 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 post in the mail. This policy benefits everybody by keeping the costs of health care down and by allowing us to concentrate on your medical needs first and foremost.

Our credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, co-insurances, and deductible amounts will, of course, still be due at the time of your visit.

If you have any questions, please do not hesitate to ask.

\*\*\*\*\*

I authorize Advanced Specialized Laser Center, Albert J. Nemeth, M.D., to charge outstanding balances on my account to the following credit card. If the billing address for this credit card differs from your home address, please advise the billing address. Thank you.

Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ American Express \_\_\_\_\_ Discover \_\_\_\_\_

Account Number \_\_\_\_\_ Exp Date \_\_\_\_\_

Name on card (Print) \_\_\_\_\_ Patient Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_