



1013 Chestnut Lane  
Suite 110  
Matthews, NC 28104  
Office: 704-585-8255  
Fax: 704-448-0660  
<https://chestnutfamilypractice.com>

## **Patient Financial Responsibility & Credit Card Policy**

---

Thank you for choosing Chestnut Family Practice as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies. Please, KNOW YOUR BENEFITS.

In consideration of the receiving services from Chestnut Family Practice, PLLC, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. You are responsible for knowing what services are or are not covered.
2. Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at time of service, and for your convenience, we accept cash and most major credit cards.
3. At Chestnut Family Practice, we require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.
4. I hereby authorize Chestnut Family Practice and the physicians, staff and hospitals associated with Chestnut Family Practice to release medical and other information acquired in the course of my treatment to the necessary insurance companies, third party payors and/or other physicians or healthcare entities required to participate in my care.
5. I hereby authorize assignment of financial benefits directly to Chestnut Family Practice and any associated healthcare entities for my services rendered as allowable under standard third party contracts. I understand that I am responsible for charges not covered by this assignment.
6. I authorize Chestnut Family Practice to securely store my credit card information and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit and storage security regulations. Once stored, I am aware that only the last five digits of my card are viewable by personnel.

Please submit any questions through the patient portal by email at [info@chestnutfamilypractice.com](mailto:info@chestnutfamilypractice.com).