Affix Patient Label

C H I

Patient Authorisation to Direct Billing Terms

I would like to use my insurance cover issued under the insurance plan of the company stated below to pay for my medical expenses incurred with Complete Healthcare International (CHI).

Name of Insurance Company

From today's date (dd/mm/yyyy)	To expiry date on credit card / membership card (dd/mm/yyyy)

I hereby agree for Complete Healthcare International (CHI) to direct bill my insurance company, as stated above, for my relevant medical expenses associated with my clinic visits.

By signing this form, I agree to the following conditions:

1. To provide a copy of my/our insurance card(s) or details, at the time of my/our clinic visit.
   Claims cannot be processed on my/our behalf without my/our insurance card(s).
2. To provide a copy of my credit card, and authorisation for CHI to process any outstanding balances, in the event that my insurance plan may not cover **in full**, or **in part**, the medical expenses related to any of my clinic visits.
3. In the event that my insurance company fails to pay, or issue an Explanation of Benefits for my clinic visit, within 60 days of my visit, I authorise CHI to process the **full outstanding balance** from my credit card.
4. It is my responsibility to deal directly with my insurance company in the case of any disputes or queries regarding my cover, or amounts reimbursed for a particular clinic visit.
5. I authorise CHI, by whom or where I have been observed or treated for any reason, to give full particulars including prior history and diagnosis to my insurance company if requested.
6. I also provide consent for the following family members (policy holders) to be included within this agreement and to use my credit card details to pay for any outstanding fees that may not be covered by my/our insurance company.

Name of Patient	Membership Number	Patient Ref (int use only)

Cardholders Signature	Name of Cardholder (block letters)	Date

*All patient's credit card details will be kept secure and confidential at all times.

Direct Billing Credit Card Details

☐ Visa ☐ MasterCard ☐ American Express ☐ Diners

Credit Card Number

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry Date (mm/yy) ☐☐☐☐

CCV Number ☐☐☐☐

Issuing Bank

Cardholder Name

☐ **Attach photocopy of both sides of the credit card**

☐ **Attach photocopy of all insurance membership card(s)**

Staff member _____