Option Care Health™ Online Account Portal
Automatic Payment – Terms and Conditions

Option Care Health's secure payment portal enables patients to manage their account online, including making automatic payments on their outstanding account balances.

You have carefully read and agree to the following Terms and Conditions for using the automatic payment system ("Automatic Payment") to pay for healthcare services provided by Option Care Health, Inc. By enrolling in and/or otherwise using Automatic Payment, you agree to these terms and conditions:

1. By enrolling in Automatic Payment and providing your credit card and other applicable banking information, you authorize Option Care Health: (i) to initiate recurring automated clearing house debit (ACH Debit) entries or debit card payments from the checking or savings account you specify or (ii) to initiate recurring charges from your specified credit card.

2. The amount withdrawn from your checking or savings account or charged to your credit card every month will be the current balance on your account. Your current balance is the amount on your statement, plus any additional charges billed to your account after your statement was issued, less any credits or payments posted to your account after your statement was issued. Upon completion of your enrollment, you understand that your monthly payments will then be automatically withdrawn from your specified checking or savings account or charges to the designated credit or debit card on the Option Care Health statement due date, unless you terminate your authorization in the manner described herein.

3. You understand that you will remain subject to any and all requirements your financial institution may have regarding pre-authorized electronic funds transfers or your debit or credit card issuer may have for pre-authorized debit or credit card transactions. Option Care Health does not impose a fee or charge for utilizing Automatic Payment. However, you agree that you are responsible for the payment of any additional fees charged by your financial institution and/or debit or credit card issuer related to your use of Automatic Payment.

4. YOU HAVE THE RIGHT TO TERMINATE YOUR AUTHORIZATION AT ANYTIME BY LOGGING INTO YOUR ACCOUNT AT https://optioncarehealth.com/bill-pay/ OR CALLING OPTION CARE HEALTH AT 866.581.2262.

5. You agree to ensure that the checking/savings account and/or debit/credit card information within your Automatic Payment account is current and up to date. You may update and/or change your payment information at any time by logging into your account at https://optioncarehealth.com/bill-pay/.

6. In the event Option Care Health is unable to charge your credit card or withdraw funds from your checking account, savings account or debit card account due to outdated and/or incorrect information, you acknowledge that you may be subject to applicable collection costs, interest charges and any fees or charges assessed by your financial institution.

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7. You understand that Option Care Health will make your monthly statement available to you online. You can access your monthly statement by logging into your account at https://optioncarehealth.com/bill-pay/ and selecting the View Statement option. You agree to review each monthly statement once available and provide Option Care Health with notice of any errors or disputed charges within at least two (2) business days prior to the statement due date.

8. YOU UNDERSTAND THAT OPTION CARE HEALTH SHALL IN NO EVENT BE RESPONSIBLE OR LIABLE FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF A PAYMENT MADE DUE TO AN INCORRECT BILLED SERVICE OR FOR ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED OR YOUR CREDIT CARD IS CHARGED.

9. Option Care Health reserves the right to revise or modify these terms and conditions (including terminating the Automatic Payment program) at any time and will provide notice of such actions by either posting them at https://optioncarehealth.com/bill-pay/ or by other methods.

10. You agree that these terms and conditions apply solely to your use of Automatic Payment and shall in no event be construed and/or interpreted as terminating, amending or modifying any other terms, agreements or policies applicable to your Option Care Health services.

Print Name of Patient	Signature	Date

Print Name of Authorized Representative	Signature	Date

As the Authorized Representative, I hereby certify that the above referenced Patient has granted me written authority as their agent or attorney-in-fact to sign this document on their behalf.

Office Use Only

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