The Center for Dermatology Credit Card Policy

The Center for Dermatology has implemented a new credit card policy. Much like other businesses such as a hotel or car rental agency, attorneys, etc., we now have a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill.

Co-pays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

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

By signing below, I authorize The Center for Dermatology to keep my signature and my credit card information securely on file in my account. I authorize The Center for Dermatology to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give The Center for Dermatology a new, valid card which I will allow them to charge over the telephone. Even though The Center for Dermatology is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

CIRCLE CARD TYPE**:** **VISA** **MASTERCARD** **DISCOVER** **AMERICAN EXPRESS**

Patient's Name (Print) _____ DOB: _____/_____/_____

Name on Card (Print) _____

Credit Card Number: _____ Exp Date: _____/_____

Please fill out information below for any other person(s) you authorize this card for:

Patient's Full Name (Print): _____ DOB _____/_____/_____

Patient's Full Name (Print): _____ DOB _____/_____/_____

Patient's Full Name (Print): _____ DOB _____/_____/_____

Credit Card Holder's Signature: _____ Date: _____

Circle billing preference: **MAIL** **EMAIL:_____** **TEXT: _____**

- ❑ **PLEASE CHECK THIS BOX IF YOU PREFER NOT TO RECEIVE A STATEMENT AND WOULD LIKE US TO BILL YOUR CREDIT CARD IMMEDIATELY FOR ANY BALANCES DUE AFTER THE PROCESSING OF YOUR INSURANCE.**