Alabama Dermatology Associates

Medical, Surgical and Cosmetic Skin Care Specialists

Authorization for Credit Card On File Payment

NOTE: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.

AUTHORIZATION

Until further notice, I authorize Alabama Dermatology Associates to charge the patient-responsible balances on my account to the following credit card:

Circle one: Visa MasterCard

Last 4 digits of my credit card: ____ ____ ____ ____

Exp. Date (mm/yy):_____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining that I must pay. I agree that Alabama Dermatology Associates may charge my credit or debit card on file for the balance due when they receive a copy of the EOB. If I do not have insurance coverage, my insurance is not accepted by Alabama Dermatology Associates, or I choose not to file for payment with my insurance, I am responsible for the entire cost of my visit and Alabama Dermatology will charge any unpaid balance to my card. The charge to my card will be made on the working day closest to the 15th or the 28th of the month. If the balance due is more than $ 100.00, I will receive a courtesy call prior to my card being charged.

Signature: _____ Date: _____

Printed Name: _____

Email, for an email receipt: _____