ADVANCED DERMATOLOGY & SKIN SURGERY

Credit Card Payment Authorization

At Advanced Dermatology & Skin Surgery, we allow you to use a credit card on file as a convenient method of paying for products and services that are not covered by your health plan or the portion that you owe after your health plan pays its portion of your claim. Your credit card information is kept confidential and secure in compliance with the Payment Card Industry Data Security Standards. We only charge your credit card for products and services that are not covered by your health plan or after your health plan makes its payment to us. You also may limit the amount that we may charge to your credit card during any billing cycle. In such event, we will charge your credit card the maximum amount for each billing cycle until all amounts due and owing by you are paid in full. The charges will be reflected on your normal credit card statements. You will not receive a separate invoice or statement for charges to your credit card on file from us.

By signing below, you authorize and request that Advanced Dermatology & Skin Surgery charge your credit card for any balance due as your financial responsibility. This authorization relates to all charges not covered by your insurance company for products and services provided, including but not limited to deductibles, co-pays, cosmetic procedures and products not covered by insurance and appointments that are missed or not timely canceled in compliance with our cancelation policy. Your card will remain securely stored for future use for payments of balances due from you.

You agree not to dispute any of the charges made to your credit card for any of the above reasons. In addition, you agree not to initiate or pursue a chargeback or payment reversal after your credit card has been charged for any of the above reasons.

This authorization will remain in effect until you revoke it in writing, which you may do at any time.

If the credit card that you give today changes, expires, or is denied for any reason, you agree to immediately provide us with a new, valid credit card, which you agree may be keyed-in over the phone. Even though we are not swiping this card in person, you agree that the new card may be used with the same authorization as the original card that you presented in person.

MAXIMUM CHARGE PER BILLING CYCLE: ☐N/A $_____ MAXIMUM

CARD HOLDER INFORMATION NAME:_____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: _____

CREDIT CARD INFORMATION CARD TYPE:
☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

CARD NUMBER: _____

EXPIRATION DATE: _____

CVV:_____

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE:_____

DATE:_____