DERMATOLOGY SAN ANTONIO

CREDIT/DEBIT CARD ON FILE AUTHORIZATION

To Our Patients:

You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be emailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Authorization

Until further notice, I authorize Dermatology San Antonio to charge the patient-responsible balances on my account to the following credit card in the amount of $_____ per month until any balance on my account has been satisfied:

Circle one: Visa MasterCard Discover Amex

Last 4 digits of my credit card: _____Exp. Date (mm/yy): _____

Please hand your credit card to the Receptionist when you check in. She will enter your card information into the secure credit card processing website. Thank you.

Signature: _____ Date: _____

Printed Name: _____

Email, if you would like an emailed receipt: _____

Note: The amount to be charged per month should not extend the payment process more than 5 months in the future, so the amount should be set to always account for no less than 20% of the account balance.