CREDIT CARD ON FILE AGREEMENT AND AUTHORIZATION FORM

At Contour Dermatology and Cosmetic Surgery Center, we now offer a credit card on file agreement as a convenient method of paying for the portion of services you owe after your health plan pays its portion of your claim. Your credit card information is kept confidential and secure, and charges to your card are made only after your health plan makes its payment to us. You have the option of limiting the amount that can be charged as well.

I, the undersigned, authorize and request that Contour Dermatology and Cosmetic Surgery Center charge my credit card for the balance due that my health plan identifies as my financial responsibility. This authorization relates to all charges not covered my by insurance company for services provided to be by Contour Dermatology and Cosmetic Surgery Center. My card will remain securely stored for future use by Contour Dermatology and Cosmetic Surgery Center for payments of balances due from me. This authorization will remain in effect until revoked by me in writing.

CHARGE LIMITS: Balances exceeding $__________ require verbal authorization from me. Charges under this amount require no further authorization.

CARD HOLDER INFORMATION		
NAME:		
BILLING ADDRESS:		
CITY:	STATE:	ZIPCODE:
PHONE:		

CREDIT CARD INFORMATION	
CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐OTHER: ________________	
LAST 4-DIGITS OF CARD NUMBER:	(PLEASE HAVE CARD AVAILABLE FOR RECEPTIONIST)
EXPIRATION DATE:	CARD IDENTIFICATION NUMBER (CVV2 CODE):

PATIENT NAME (PRINT): ____ DATE: ____________________

PATIENT SIGNATURE: ____ DATE: ____________________

OFFICE USE ONLY		
Patient Chart Number: ___________	☐ Inputted into E-Processing	Initials of Receptionist: ________