

Statement of Policy Regarding Credit Card Information

To Our Valued Patients:

Thank you for choosing Skin Care Specialty Physicians for your health care needs. We are happy to bill your health insurance company for the medical services that you receive in our office. However, various insurance plans pay differently, sometimes resulting in a balance which is due from you. For this reason, we will keep your credit card information on file to make it easy for you to pay any balances that may occur. This policy will benefit you in the following ways:

- Save you the expense of checks and postage
- Provide you with a convenient method of payment
- Keep the cost of your health care down
- Refunds if applicable after insurance adjustments

We will contact you prior to processing any credit card payment over \$100.00.

Please fill in the requested information on the lines provided below:

\_\_\_\_\_  
Cardholder Name:

\_\_\_\_\_  
Patient Name:

I have read the above and understand that all account balances which I incur at Skin Care Specialty Physicians are ultimately my responsibility. I authorize Skin Care Specialty Physicians to process payments for balances on my account using the credit card information which I have provided.

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date

Check this box if you do NOT wish to authorize your credit card for balances.

\_\_\_\_\_  
Patient name (please print)

\_\_\_\_\_  
Date