***CREDIT CARD ON FILE POLICY***

At Mid-Atlantic Skin, we require signed authorization for keeping your credit or debit card on file as a convenient method of payment for the services or portion of the services, that your insurance does not cover, but for which you are liable.

Your credit card information is kept confidential and secured, and payments to your card are processed only under and after your authorization; payments to your card are processed only after the claim has been filed and processed by your insurance carrier, and the insurance portion of the claim has been paid and posted to the account.

I authorize Mid-Atlantic Skin to charge the portion or total amount of my bill that is my financial responsibility to the following credit card on file:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned, authorize and request Mid-Atlantic Skin to charge my credit card for balances due for services rendered that have been identified as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Mid-Atlantic Skin.

This authorization will remain in effect until I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, cancel this authorization. To cancel, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, must give notification to Mid-Atlantic Skin in writing and the account must be in good standing.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **DO NOT** wish to provide Mid-Atlantic Skin my credit card information at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Name (Please print)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Signature*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date*