A close-up of a logo

Description automatically generated

# Credit Card on File Authorization

At Mid-Atlantic Skin Surgery Institute, 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 doesn’t cover.

Your credit card information is kept confidential and secured, and payments to your card are processed for due Co-payments determined by your insurance company when you present to your appointment. Any remaining payments will be charged to your card only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account as applicable.

I authorize and request Mid-Atlantic Skin Surgery Institute 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 Surgery Institute.

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

( ) I would like to be notified by Mid-Atlantic Skin billing staff prior to the charge to my credit card on file.

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party if a Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_