SOUTHLAKE DERMATOLOGY

Angela Bowers, MD Sara Greer, MD Cheryl Hickey PA-C Beth Palazzetti PA-C
1170 N. Carroll Ave. Southlake, TX 76092
www.southlakedermatology.com
Main 817-251-6500 Fax 817-442-0550

CREDIT/DEBIT CARD AUTHORIZATION FORM

Patient Name _____ Date of Birth _____
Additional Family Members:
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

The purpose of this form is to authorize Southlake Dermatology to retain a valid credit card number on file for you as our patient. Our HER allows us to scan your card and host it with encryption. The credit card number may not be seen by any staff except for the last 4 digits. This will allow you and us the convenience of charging any balances owed after insurance has paid on your account. Your supplied credit/debit card will be charged only under the following circumstances:

1. Southlake Dermatology will charge the credit/debit card listed below for all current patient balances (following insurance payments) and a receipt will be kept in your patient chart. This form serves as your consent for future charges for all current patient balances on your account.
2. If you, as a patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Southlake Dermatology reserves the right to charge the card listed $30 for our standard no-show fee and a receipt will be sent to the current address on file. This notice serves as your consent to being charged for any and all no-shows.
3. You will receive a notice from your insurance company regarding your bill and the amount that should be owed to us. Within 3 days of that notice you can expect to see your card charged for the balance. If you require any separate receipt for your Flex Spending Plan or HSA then please let us know and we will supply you with the necessary documentation.

Other than the conditions mentioned above, under no circumstances will Southlake Dermatology charge your credit/debit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be kept confidential.

Acknowledged, Agreed & Accepted:
Having read this form, my signature below acknowledges that I voluntarily give my authorization and consent to allow my credit/debit card to be charged accordingly for the conditions listed above. I understand that this will not compromise my ability to dispute a charge or question my insurance company's determination of payment.

Debit or Credit Visa Mastercard Discover (This can also be your HSA or Flex Spending)

LAST 4 digits of Account _____ Exp. Date _____ Verification code (3 digit code) _____

Street number of billing address _____ Billing zip code _____
(this is required for us when we manually process payments)

Name on card (please print) _____

Signature _____ Date _____