COLUMBIA SKIN CLINIC

Authorization for Credit Card On File

Authorization:

Until further notice, I authorize Columbia Skin Clinic to keep my credit card information and signature on file and to apply charges to the credit card listed below for patient-responsible balances on the below listed account(s).

I understand that once insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB) detailing any remaining portion to be paid by me from my insurance carrier and that Columbia Skin Clinic will also receive an EOB. I agree that Columbia Skin Clinic may charge my credit card on file for the balance due 30 days after the date of my mailed billing statement. By signing below I authorize my card to be run for the balance due on my account(s) for that billing cycle. I will receive a receipt via email for any transactions posted to my card.

I understand that I must contact Columbia Skin Clinic if there are any changes to my credit card information to include, but not limited to, card expiration, lost/stolen cards, credit limit reached, card reissue, or any additional reason that might affect proper processing of the card on file. I understand that should attempts to charge my credit card for patient responsibility amounts as assigned by my insurance carrier be declined for any reason, I will receive statements for the balance due and, as with any negligent patient balances due to Columbia Skin Clinic, my account may become eligible for turnover to a collections agency if I fail to respond to statements in a timely manner.

Type of credit card: ☐ Visa ☐ MasterCard ☐ Discover

Last 4 Digits: _____ Expiration Date (MM/YY): _____

I authorize credit card on file for the following account(s):

☐ My Account ☐ Other: _____ Please list name(s) and date(s) of birth

Email Address: _____

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____