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 on or around four (4) weeks 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: _____