PATIENT CREDIT CARD ON FILE AGREEMENT

OVERVIEW & PURPOSE

We have implemented a policy which enables you to maintain your credit card information securely on file. In providing us with your credit card information, you are giving **Alexandria Associates In Dermatology** permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at the time of service. By signing this, you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays*:* Co-pays are due at the time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Alexandria Associates In Dermatology will notify you via mailed patient statement. **If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card.** A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I, the undersigned, am an authorized user of the credit card swiped today. I hereby authorize Alexandria Associates In Dermatology to charge my credit card for balances due for items and services provided by Alexandria Associates In Dermatology. I agree to pay all amounts charged pursuant to this authorization in accordance with the issuing bank cardholder agreement.

CHECK CARD TYPE: ❒ VISA ❒ MASTERCARD ❒ AMERICAN EXPRESS ❒ DISCOVER

Patient Signature: ______________________________

Credit Card Holder's Name: ______________________________

Last 4 digits of Credit Card: ______________ Expiration Date: ______________

IF YOU WISH TO LEAVE THIS CREDIT CARD ON FILE FOR OTHER PATIENT(S), PLEASE PRINT NAME(S) BELOW:

Patient Full Name *(Please print)*: ______________________________