

Credit Card on File Agreement – Effective January 1, 2020

Lam Dermatology and Associates has implemented a new credit card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient’s responsibility, such as copay, deductible and co-insurance.

Co-pays are still due at time of visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Lam Dermatology of the balance due, if any. At that time, the billing department will issue out one statement via mail which the patient will have 30 days to pay the balance or make other payment arrangements. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the billing department will notify the patient via a mailed letter. The patient will have an additional 30 days to arrange payment before the bill is subject to additional collection activity.

If you have any questions about the policy, please email your inquiries to info@lam-dermatology.com.

I authorize Lam Dermatology and Associates to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility.

If the provided debit/credit card has changed, expired or denied for any reason, I agree to immediately give Lam Dermatology and Associates a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	<input type="checkbox"/> American Express
Patient’s Name (print):			
Date of Birth (mm/dd/yyyy):			
Cardholder Name (print):			
Last Four Digits of Debit/Credit Card Number:			Exp. Date:
Card Billing Address:			
<input type="checkbox"/> Please check this box if you prefer not to receive a statement and would like us to bill your debit/credit card immediately for any balances due after the processing of your insurance.			

Debit/Credit Card Holder’s Signature: _____ Date: _____

OFFICE USE	
Authorization Received by: _____ (Initials)	Date: _____