

Optional

Credit Card Save on File

For your convenience and as an option, we kindly request that you leave a credit card on file which may be used to reduce your remaining balance after insurance pays. Please complete and sign the following:

Credit Card Authorization

_____ I authorize Lam Dermatology to bill my insurance for the services rendered today.
Initials Upon receipt of payment from my insurance company,
I authorize Lam Dermatology to charge the below listed
credit card in the amount of the remaining unpaid balance.

_____ I understand that cosmetic procedures are not billed to my insurance. Should
Initials there be a remaining balance on cosmetic services, I authorize Lam Dermatology to
charge the below listed credit card in the amount of the remaining unpaid balance.

_____ An email will be sent to notify me of the additional charge to my credit card.
Initials

Patient Name _____ Patient's Date of Birth _____

Credit Card Billing Address:

Address line 1

Address line 2

City, state, zip code

Card holders Email address

Best number to be reached

Name as it appears on credit card

Last four numbers on credit card

Credit card expiration date

Cardholder's Authorizing Signature

Date

Office Use Only

Employee initials _____

Date Saved _____