

Credit Card on File Agreement

Lam Dermatology and Associates has a credit card on file requirement. 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 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. That amount will automatically be charged to your card after two (2) net-30-day statements have been sent to you via mail and/or e-mail. In the event that your card has reached its limit maximum, the bill will be 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:	
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: _____