PORT JEFFERSON DERMATOLOGY
DERMATOLOGY - ADULTS AND CHILDREN
DERMATOLOGIC SURGERY AND MOHS SURGERY

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Credit Card Authorization

To all of our new and established patients:

We have implemented a policy asking patients to keep a credit card on file at the office to make things more convenient for our patients and staff. Having the card on file makes check in and check out faster, easier and more efficient. Your card information will be held securely in your chart and the hard copy will be properly discarded. Once your insurance company has paid their portion and notified us of the amount of your share of the claim, a statement with any remaining balance owed will be mailed to the address you provided upon check in. You will have also received an explanation of medical benefits from your insurance company that would make you aware that there is a portion of the fee that is your responsibility, so this balance will not come as a surprise to you.

The advantage is, you will no longer have to write out and mail us checks. You can call our office and permit our staff to use your card on file for the balance. This does not compromise your ability to dispute a balance or question your insurance company's determination of payment. With that being said, if your balance is outstanding past 60 days we will charge your card on file.

Co-pays, co-insurance and any deductibles remain due at the time of your visit.

Healthcare is a personal relationship between a patient and physician. While we don't believe healthcare is just like any other product, practices of insurance companies have changed over the years and this policy is necessary and benefits everybody in helping to keep the cost of healthcare down.

We thank you for your understanding of this policy.

Circle One	Credit Card Number	Exp Date	Security Code	Billing ZIP
Visa MC Discover				

I, (print) _____, have read the above and understand that my credit card will be charged for any balances, which are the patient's responsibility determined by my insurance as well as any fees associated with the practice's cancellation policy. I, the undersigned, authorize Port Jefferson Dermatology to charge the credit card indicated on this authorization form according to the term outlined above. I certify that I am an authorized user of this card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature (required):_____Date (required): _____