Rochester Dermatology Clinic, P.C.

Patient Credit Card Consent Form

To our Patients:

It is our understanding that many of our patients lead extremely busy lives. To help make our patients lives simpler, Rochester Dermatology Clinic is now offering the ability to securely store a credit card on file. In doing so, this will allow us to apply payment to any remaining balance left unpaid by your insurance company. Once applied, a confirmation of your payment will be submitted to you via e-mail. If this sounds like a viable option for your lifestyle, we ask that you please provide your credit card information below, either to a staff member or on our secure website.

Our office believes this option will help to relieve patients from worries like whether they remembered to pay their bills or put a check in the mail. We are also hoping that this will work to our advantage by giving us yet another option to better serve you, the patient.

This in no way will compromise your ability to dispute any charges or question your insurance company's determination of payment.

Copays, per usual, will still be due at the time of your visit. If you have any questions, comments, or concerns about this payment method, please do not hesitate to ask.

Sincerely,
Rochester Dermatology Clinic
248-853-3131

I authorize Rochester Dermatology Clinic to charge outstanding balances for the listed family members to the following credit card:

Patient Name: _____ Date of Birth: _____

Family Member: _____ Date of Birth: _____

Family Member: _____ Date of Birth: _____

Family Member: _____ Date of Birth: _____

◯ Visa ◯ Mastercard ◯ Amex ◯ Discover (Please circle one)

Credit Card#_____ Exp Date MM_____/YY_____ CVV_____

Name on card (please print)_____

Email address for receipts _____

Signature_____ Date_____/_____/_____