Dermatology for the Family

149 East Avenue, Suite 20
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Tel: (203)853 – 1874

As of November 1, 2020, we are requiring all patients to maintain a credit card on file due to the increase of patient deductibles and coinsurance. This information is kept secured for your protection.

CARD ON FILE AUTHORIZATION
FOR FUTURE AND PAST DUE BALANCES
Credit Card, Debit Card, HSA, HRA and FSA Cards Accepted

I authorize Dermatology for the Family to charge the portion of my bill that is my financial responsibility to the following Credit, Debit, HSA, HRA or FSA card:

Please circle: Amex Discover MasterCard Visa HSA FSA HRA

Credit card Number ______________________________

Expiration date ______________ V-code: ______________

Cardholder name ______________________________

Billing address ______________________________

City, State, Zip code ______________________________

I (we), the undersigned, authorize and request Dermatology for the Family to charge my card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. If my credit card declines, I will provide a new credit card number. I understand that a copy of my credit card will be kept on file.

This authorization relates to all payments, not covered by my insurance company, for services provided to me by Dermatology for the Family.

I am authorizing that this credit card on file can be used on my past due balances for my account.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30-day written notification to Dermatology for the Family and the account must be in good standing.

Patient Name (Print) ______________________________

Patient Signature
(or guardian if patient is under 18) ______________________________

Date ______________________________