Credit Card on File Policy

Thank you for choosing Dermatology Associates of Southwest Washington for your dermatological needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring more costs to our patients. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit.

Effective 1-1-2019, we have implemented a policy requiring a credit card be held on file as a seamless way for our patients to pay their bills. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of your patient responsibility.

- Once insurance pays for your visit, the credit card on file will automatically be charged for remaining balances up to $150.00.
    - We will notify you, by email, THREE (3) DAYS BEFORE we charge your card. This will allow you the opportunity to call our office if this presents a problem for you or if you need to update your card on file.
    - A receipt will automatically be emailed to you after the payment has been processed.
- Once insurance pays, if the remaining balance is greater than $150.00, we will contact you for additional payment.

If the credit card we have on file for you changes, please notify our office IMMEDIATELY by phone or email. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.

I authorize Dermatology Associates to charge the portion of my bill that is my financial responsibility to the following credit or debit card with one of these options:

□ **I authorize a charge against my credit card for the full remaining patient balance.**

□ **I authorize a charge against my credit card for any patient balance up to $150.00.**

If there are additional monies owed greater than $150.00, a billing member will call to discuss the remaining balance.

Name on Card: _____

Card Number / Last 4 digits: _____

Expiration Date: _____ CCV # _____ Zip Code: _____

I, the undersigned, authorize and request Dermatology Associates of Southwest Washington to charge my credit card, indicated above, for balances for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Dermatology Associates of Southwest Washington.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Dermatology Associates of Southwest Washington in writing and the account must be in good standing.

Patient Name (print) : _____

Patient Signature : _____ Date : _____ / _____ / _____