May River Dermatology

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Card on File Consent

For your convenience, we have implemented a policy which enables you to maintain your credit/debit card information on file with us. With your consent, this information will be securely held to cover future charges and additional fees.

Signing this consent in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

_____

I hereby authorize May River Dermatology, LLC to keep my Card information on file for payment of any and all charges for medical services for which I am financially responsible and that remain unpaid after two (2) statements have been mailed.

I understand that you will send me a receipt reflecting any amount charged to my Card.

If my card information changes for any reason, I will notify you. This consent shall remain in effect until I give you written notification of termination.

Agreed to:

Printed Name: _____ Signature: _____ DOB: _____

☐ VISA ☐ MC ☐ DISCOVER Credit Card #_____

Office Notice: We currently do not keep American Express cards on File.

Name as it appears on the credit card: _____

Expiration Date (MM/YY): ___/___

Security Code (3 or 4 digit # printed on front or back of card): _____

Mailing address for card: _____

Office Notice: Bottom section of this form is not to be scanned or attached to patient chart. Credit card information is to be shredded immediately after encryption into database.