Dermatology & Skin Surgery Center of Princeton

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payments of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information

PATIENT'S NAME: ____

NAME, AS IT APPEARS ON CREDIT CARD: ______________________________

BILLING ADDRESS: ____

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EMAIL ADDRESS: ____

AMEX/DISC/MC/VISA CARD#: _____________________________________

EXPIRATION DATE:________/__________**VERIFICATION CODE (3 of 4 DIGITS)** __________

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Dermatology & Skin Surgery Center of Princeton to charge the above credit card account for any co-payment, co-insurance, deductible and/or charge not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.