COLUMBIA SKIN CLINIC, LLC
CREDIT CARD AUTHORIZATION FORM

The purpose of this form is to authorize Columbia Skin Clinic, LLC to retain a valid credit card number on file for you as our patient. This form will be kept confidential, and only authorized staff have access to the information. (Same process you would go through for hotels, rental cars, etc.)

Your supplied credit card will be charged **ONLY** under the following circumstances:

1. Columbia Skin Clinic, LLC reserves the right to charge the credit card listed below for all patient responsible balances, and a receipt will be sent directly to you. This notice serves as your consent to being charged for all current patient balances on your account. This form will be destroyed upon entry in our secure credit card gateway. This notice will immediately be cross cut shredded.
2. Other than the conditions mentioned above, under NO circumstance will Columbia Skin Clinic, LLC charge your credit card for anything not discussed personally with you. In conjunction with HIPAA regulations, PCI DSS Compliance (Payment Card Industry Data Security Standards) all credit card information will be confidentially kept in a professional, secure credit card gateway and no credit card information will be kept by Columbia Skin Clinic, LLC. Only authorized staff will be able to access this information.

This agreement in no way impedes your access to quality of care or compromises your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, co-insurance, non-covered services, and deductibles are due at the time of the visit.

Acknowledged, Agreed, & Accepted:
Having read this form and talked with the physician and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

Patient Name: _____Date of Birth:_____

_____ ***Office Use Chart#:***_____
Cardholder's Signature Date
(*person authorized to sign for patient*)

Name as it appears on card:_____

Billing Address:_____

Discover/MC/Visa Card #: _____

Expiration Date: _____/_____ Verification Code (3 or 4 DIGITS):_____

Other family members whose balances are also authorized to place on this credit card:

Name:_____Date of Birth:___/___/___ Account#:_____

Name:_____Date of Birth:___/___/___ Account#:_____