Downtown Dermatology L.L.C.

291 Broadway Suite 1803
New York, N.Y. 10007

Tel: (212) 233-2995
Fax: (212) 227-6577

Credit Card Authorization Form

Dear Patient,

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical services that we provide you. Co-payments, deductibles, co-insurance, and charges for medical services are determined by your specific health care coverage. Please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits.

Since you are ultimately responsible for the medical services provided to you, **it is our policy to obtain your credit card number and authorization to process payment for charges not covered by your insurance carrier.** These health benefits are decided by your employer and selected health plan.

In providing your credit card information below, you authorize payment by credit card for services in the absence of coverage by your health plan including, but not limited to, co-payments, deductibles, co-insurance, and all uncovered medical services rendered by Downtown Dermatology L.L.C. and received by you.

Your credit card information will be kept on file. The staff of Downtown Dermatology will contact you by phone or email to inform you of outstanding balances and to provide you with a copy of the EOB as proof of non coverage prior to use of the credit card.

***Please note that Downtown Dermatology has the right to refuse medical services if credit card information is not provided.**

We thank you in advance for your cooperation,

Sincerely,
Downtown Dermatology

Credit Card Information

Patient's First Name:_____ Last Name:_____

Name on Card:_____

Card Type: Visa ( ) Master Card ( ) American Express ( )

Card Number: _____ Expiration Date: ____/____/____

Security Code: _____

Signature_____ Today's Date: ____/____/____