GOLDMAN DERMATOLOGY, PLLC
150 BROADWAY, SUITE 1110
NEW YORK, NY 10038

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 care services that we will provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but 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 payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.

Your health benefits, including your responsibility for co-payments, deductibles and co-insurance is a decision made by your employer, not this office or your health plan.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but not limited to, co-payments, co-insurance, deductibles and/or uncovered services) in an amount not to exceed $400.00 per billing cycle. Please know that Goldman Dermatology mails monthly statements when a balance is due on a patient account. The practice also sends emails and telephones patients to resolve account balances. A credit card will only be charged after two monthly statements are mailed and in the event of non-payment or any communication from the patient.

PLEASE HAND CARD TO RECEPTIONIST TO SWIPE INTO HIPPA SECURE SYSTEM

Patient Name _____

Name on Credit Card _____

Signature _____ Date _____