AGREEMENT TERMS

Patient Name:_____

I agree to allow the practice to charge my credit card for the balance due, as determined by the final adjudication, of any insurance claim resulting from providing dermatology services for the above patient.

Visa / Master Card / Amex (circle one) Exp Date: __ __ / __ __
Account number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I agree to these charges under the following conditions:

- Any charges to the card will take place within 90 days of the final explanation of benefits from the patient's insurance company.
- The amount charged to my card will not exceed $250.00 for any one claim.
- I will receive a bill from the practice for any balance greater than $250.00 for which the patient is liable.
- I will receive a receipt or notification for any amount charged to my card once the transaction has been executed.
- I can cancel this authorization at any time upon written notice to the practice which will take effect for any service provided subsequent to the receipt date of the notice. Any notice of cancellation is effective on the date it is actually received at the practice.
- I acknowledge that I am completing the agreement based on the promise that the money is available on my credit card. I intend to be legally bound by the terms of this agreement.

Cardholders Name: _____

Cardholders Signature: _____

Date: _____

Practice Signature: _____

Please contact us if any questions or concerns:

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