DERMATOLOGY ASSOCIATES OF WEST MICHIGAN
Credit Card Authorization

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit/debit card number and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit/debit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everyone in helping to keep the cost of health care down.

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

Co-pays due at the time of the visit will still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,
Dermatology Associates of West Michigan

_____ ***I DECLINE this offer to keep my credit card on file***

_____ ***I ACCEPT this offer to keep my credit card on file (continue below)***

We can scan your credit/debit card directly into our computer if you prefer, or you can complete this form and we will keep it on file in the Billing department. This information will be kept strictly confidential.

Patient Name: ______________________________________ Date of birth: ________________________
Office Use – Account #: _______________

I have read and agree to all of the terms and conditions above. I authorize Dermatology Associates of West Michigan to charge outstanding balances on my account to the following credit/debit card:

Visa Master Card Discover American Express Other:___________________

Credit Card #: ____

Name on Card (please print) ____

Expiration Date ________________________ 3 digit # on back of card ________________

Cardholder's Signature __________________________________ Date _________________

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

Name: _____________________________________Date of birth: ________________

Name: _____________________________________Date of birth: ________________

Please return this completed form to a clerical staff member