DERMATOLOGY ASSOCIATES (708)444-8300

18425 West Creek Dr. Ste F
Tinley Park, IL

13401 S Ridgeland Ave
Palos Heights, IL 60463

CREDIT CARD INFORMATION RETENTION POLICY

Thank you for providing us with your insurance information. Claims for your services will be filed promptly and payments will be applied to charges for today's services. You may have noticed that the changing healthcare market has created an increase of financial responsibility being shifted to the patient. This has resulted in patient balances, high deductibles, uncovered services, increased copays and co-insurances . For this reason, we, as many other physician practices, are adopting new financial policies that will create more efficient and convenient resolution of patient balances.

As a convenience to our patients, we ask that you provide us with your credit card information. This information will be kept in a **confidential and secure file.** We are committed to following the strict rules and guidelines established by HIPAA to insure that your privacy is protected and we maintain strict standards to safeguard your credit card information as required under the Payment Card Industry Data Security Standard (PCI DSS). This convenient protocol will allow you to pay for the portions of your services that are not covered by your insurance plan in an easy and secure manner. In the case of overpayments, refunds will also be processed automatically. Charges for your visit/ treatment will be submitted to your insurance company and if there is a patient balance due, our billing department will notify you by email or phone of the credit card transaction.

Please complete the following:

Patient name: _____ Patient date of birth_____

Account guarantor (if other than patient) _____

□ I authorize Dermatology Associates to keep my credit card on file with the understanding that charges will be processed for charges not paid by my insurance. The credit card will be used as a convenience to pay for patient balances as determined by my insurance company. Charges less than $250 will be processed automatically. Patient accounts higher than $250 will require a verbal authorization.

Signature _____date _____

It is most convenient if my credit card is charged on the following day

□ 7th □ 14th □ 21st □ 28th of the month

CREDIT CARD INFO:

Credit card type □ Visa □ MasterCard □ Discover □ Flex Spending/HealthSavings

Card# _____ Exp date _____

CSV code_____ Mo/Year

Name as shown on card _____

Bill to address _____ zip code _____

Contact phone# _____email address _____

Send receipt by □ mail □ email □ text confirmation

PLEASE NOTE: **If your credit card information is not on file, there will be a billing fee of $5 added to your account every time a monthly statement is mailed to you .**