Credit Card Authorization Form

The cost of the virtual visit is $70 for all patients.

At this time, most insurance companies do not pay for this service. Because of this, we will charge your credit card $70 when your visit is completed. For your convenience, we can also file insurance on your behalf. If your insurance pays, we will reimburse you any overpayment made on your account.

If for some reason your visit cannot be completed (e.g. you need to return to the office for your follow up), your card will not be charged.

Please complete all fields. You may cancel this authorization at any time by contacting our office. This authorization will remain in effect until cancelled.

CREDIT CARD INFORMATION
Card Type: ☐ MasterCard ☐ Visa ☐ Discover
Cardholder Name (as shown on card):
Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __
Expiration Date (mm/yy): __ __ / __ __
CVC (3 digit code on back): __ __ __
Credit Card Billing Zip Code: __ __ __ __ __

I, ____, authorize Dermatology Clinic of N MS PLLC to charge the credit card above in the amount of $70 for agreed upon purchases. I understand that my information will be saved on file for future transactions on my account.

______________________________________ ______________________________

Customer Signature Date