REN Dermatology & LASER CENTER

Credit Card on File Authorization Form

Patient Name: _____ **Date of Birth:** _____ /_____ /_____

REN Dermatology is offering a secure and convenient method of payment for the portion of services your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed to, and processed by your insurance carrier, and the insurance portion of the claim has posted to your account. In the event that valid insurance information was not provided at the time of services, your credit card on file will be charged the full amount for your services rendered.

By signing this form, I am authorizing REN Dermatology to capture my credit card information and securely store my credit card on file.
I authorize REN Dermatology to charge my credit card on file for any balance owed on my account.

I that REN Dermatology may charge my credit card on file for the balance due when they receive a copy of the explanation of benefits (EOB) from my insurance. This authorization relates to all balances not covered by my insurance company for services provided by REN Dermatology. This could be amounts resulting from balances relating to co-payment, deductible, co-insurance, non-covered services, or denials for inactive coverage or eligibility, but is not limited to these scenarios.

Cancellations with less than 24-hours' notice and No-Show fees will also be charged to the card on file.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization to REN Dermatology. A written notice must be submitted to REN Dermatology 155 Covey Drive, Suite 200 Franklin, TN 37067.

I certify that I am the authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated on this form.

Accepted Forms of Payment: ***Visa Mastercard Discover American Express***

Card Holder Name: _____

Credit Card Number: _____/_____/_____/_____

Expiration Date: _____/_____

CVV: _____

- By declining to save my card on file, I understand that I am responsible for paying for all services in full at the time of my visit.
  I decline saving my card on file. _____ *(print initials)*

Signature (Parent/Guardian): _____ ***Date of Signature:*** _____

Relationship to Child if Minor : _____