

**Chart #**

# CREDIT CARD ON FILE AGREEMENT

Patient Name (Please Print) Date of Birth

The Skin Firm, LLC has implemented this credit card policy to provide the best patient care while ensuring a simple and cost-effective billing process. This policy is intended to make it more convenient for you to pay for the portion of your services that are your responsibility such as copays, deductibles, co-insurance or other unpaid balances. Our office will keep your credit card on file in a secured location. Credit card information is stored securely on a Health Insurance Portability and Accountability Act (HIPAA) compliant Payment Card Industry-Data Security Standard (PCS-DSS) server.

* Any service that is not covered by your insurance company, for any reason, is your financial responsibility. **Any unpaid balances will be charged to the credit card on file 10 days following insurance response.** Please note that this policy does not impact your ability to dispute charges or question your insurance company’**s** determination of payment.

# All cosmetic treatments and co-pays must be paid at the time of service or will be charged to credit card on file.

**CANCELLATION POLICY:**

* **MEDICAL PATIENTS:** We require at least 24 hours’ notice to cancel or reschedule a medical appointment. A $25 fee will be charged to the credit card on file for a missed General Appointment and $125 for a missed Surgical Appointment.
* **COSMETIC PATIENTS:** We require at least 24 hours’ notice to cancel or reschedule a cosmetic appointment. A $50 fee will be charged to the credit card on file for a No Show.
* **LATE ARRIVAL:** All patients who are more than 15 minutes late for their appointment will need to be rescheduled.

*We accept cash, checks, Visa, MasterCard, Discover, and American Express. Please note that personal checks are not accepted for cosmetic procedures or products.*

C**redit Card Type (FRONT DESK WILL SWIPE YOUR CARD)**

**(Visa, MasterCard, Disc, AMEX) Health Spending Acct: Yes** **No**

**Exp Date**

**Exp Date**

I certify that I have been informed of and accept the Credit Card on File policy. If the credit card I provide today undergoes any changes, expiration, or is denied for any reason, I agree to promptly provide the Skin Firm with a new, valid credit card. I authorize The Skin Firm, LLC, or its agent, to charge my credit card any outstanding balances as noted above. This authorization will remain in effect until revoked by me in writing.

Date / /

Signature of Patient (or Legal Representative)

Signature of Patient Service Representative

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