RODGERS DERMATOLOGY
3880 Parkwood Blvd., Suite 102, Frisco, TX 75034
www.rodgersderm.com
Main 972-704-2400 Fax 972-704-2255

CREDIT/DEBIT CARD AUTHORIZATION FORM

Patient Name _____ Date of Birth _____

Additional Family Members:

Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

The purpose of this form is to authorize Rodgers Dermatology to retain a valid credit card number on file for you as our patient. Our EHR allows us to scan your card and save it in your personal file that is password protected. This will allow you and us the convenience of charging any balances owed after insurance has paid on your account. Your supplied credit/debit card will be charged only under the following circumstances:

1. Rodgers Dermatology will charge the credit/debit card listed below for all current patient balances (following insurance payments) and a receipt will be kept in your patient chart. This form serves as your consent for future charges for all current patient balances on your account.
2. If you, as a patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Rodgers Dermatology reserves the right to charge the card listed $30 for our standard no-show fee and a receipt will be sent to the current address on file. This notice serves as your consent to being charged for any no-shows.
3. You will receive a notice from your insurance company regarding your bill and the amount that should be owed to us. Within 5 business days of that notice you can expect to see your card charged for the balance. If you require any separate receipt for your Flex Spending Plan or HSA then please let us know and we will supply you with the necessary documentation.

Other than the conditions mentioned above, under no circumstances will Rodgers Dermatology charge your credit/debit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be kept confidential.

Acknowledged, Agreed & Accepted:
Having read this form, my signature below acknowledges that I give my authorization and consent to allow my credit/debit card to be charged accordingly for the conditions listed above. I understand that this will not compromise my ability to dispute a charge or question my insurance company's determination of payment.

Debit or Credit Visa Mastercard Discover AMEX (This can also be your HSA or Flex Spending)

Full Account Number _____Exp. Date _____ Verification Code _____

☐ Address same as on patient paperwork.

Billing address _____ Billing zip code _____
(this is required for us when we manually process payments)
Name on card (please print) _____

Signature _____ Date _____

☐ I decline to give my credit/debit card to Rodgers Dermatology at this time. This does not relieve me of my financial responsibility.