Credit Card on File Authorization Form
Clear Dermatology

Please complete all fields.

Credit Card Information
Card Type: MasterCard VISA Discover AMEX
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ Security Code_____
Cardholder ZIP Code (from credit card billing address): _____

Credit Card on File (CCOF) will be used to pay account balances, after insurance adjudication, which remain unpaid after 60 days. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our billing office showing what your total patient responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

By signing below, I authorize Clear Dermatology to keep my signature and my credit card information on-file securely with Payer Express. I authorize Clear Dermatology to charge my credit card for any outstanding balances after 60 days if unpaid. This authorization may also be used to pay copays and balance due for virtual visits.
Additionally, if the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Clear Dermatology a new, valid credit card which I will allow them to charge over the telephone. Even though Clear Dermatology is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented. In the event a new credit card is not promptly received, my outstanding balance will be sent to collections.

_____ _____
Patient Name (print) Date of Birth

_____ _____
Cardholder Name (print) Relationship to patient

_____ _____
Cardholder Signature Date