

# LASER SKIN CARE CENTER

## Credit Card Authorization

To Our Patients:

**You have the flexibility** of providing us with a credit/debit with (VISA/MC Logo) card number and the information will be held securely until your insurance has paid its portion and notified us of the remaining amount that is your responsibility. At that time, any remaining balance owed by you will be charged to your credit/debit card, and a copy of the charge will be mailed to you. **It is our policy to treat your financial information with the same respect and privacy guidelines as your medical records.**

**Co-pays due at the time of the visit will still be due at the time of the visit.**

Sincerely yours,  
Laser Skin Care Center

-----  
We can scan your credit/debit card directly into our computer if you prefer, or you can complete this form and we will keep it on file in the Billing department. This information will be kept strictly confidential.

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Office Use – Account #: \_\_\_\_\_

I have read and agree to all of the terms and conditions above. I authorize Laser Skin Care Center to charge outstanding balances on my account to the following credit/debit card:

Visa    Master Card    Discover

Credit Card #: \_\_\_\_\_

Drivers Licence #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ 3 digit # on back of card: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(typing full name serves as an electronic signature)