SOMA
Skin & Laser

CREDIT CARD AUTHORIZATION

Your insurance company will be billed for applicable charges for all visits to SOMA Skin & Laser, today and in the future. By signing this form, you agree that any remaining balance due as the patient's responsibility for any service relating to any visit will be charged to your credit card if unpaid after our normal collection process. The agreed maximum amount to be charged to your credit card for services at SOMA Skin and Laser is $200. Any remaining balance will remain your responsibility and will be subject to our usual collection policy.

Last Name: _____

First Name: _____

Credit Card: AMEX Visa MC Discover

Card #: _____

Exp. Date_____

Billing Address**:** □ Same as on file

THIS FORM IS SHREDDED ONCE IT IS SCANNED INTO OUR HIPPA-COMPLIANT ELECTRONIC MEDICAL RECORDS SYSTEM.

YOUR CREDIT CARD WILL NOT BE CHARGED UNLESS A BALANCE REMAINS OUTSTANDING AFTER COMPLETION OF OUR NORMAL COLLECTIONS PROCESS.

THIS AUTHORIZATION IS REQUIRED OF ALL MEDICAL PATIENTS WITHOUT EXCEPTIONS. YOU HAVE NOT BEEN SELECTED PERSONALLY IN ANY WAY.

Signature: _____

Date: _____