PATIENT INFORMATION			
LAST NAME		FIRST NAME	M.I.
SSN	DATE OF BIRTH	SEX	MRN
STREET ADDRESS			
STREET ADDRESS CONTD.			
CITY		STATE	ZIP CODE
HOME PHONE	CELL PHONE		EMPLOYER NAME

Credit Card on File Dermatology and Surgery Associates and Bronx Plastic Surgery

Credit Card Policy

The undersigned agrees that all information provided to the applicable financial Institution is accurate and complete. Once your claim is finalized by your insurance carrier you will receive a statement in the mail, this may or may not be received prior to Auto Payment being charged to your credit card. You will also receive an email and text notification advising you of the balance due. At any time, you may access your account statement on our patient portal by logging in via navaderm.ema.md. If no payment is received within 21 days the credit card on file will be charged.

By completing and signing this form, you authorize Associates in Dermatology and Surgery Associates and Bronx Plastic Surgery (The Practice) to charge your credit card on file for any balance due as set forth on the Explanation of Benefits from your Insurance company that Is not paid by your Insurance company (the "Patient Responsibility"). The Explanation of Benefits from your insurance company determines the Patient Responsibility.

I have read this Consent and Authorization to Process Credit Card Payments and agree to the terms and conditions set forth above. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of the practice. Furthermore, I agree to assign all health insurance benefits directly to Dermatology and Surgery Associates and Bronx Plastic Surgery and understand that I am responsible for any costs of Patient Responsibility not covered by my health Insurance which shall be charged to the credit card as set forth above.

Patient / Agent / Guardian Signature