
Credit Card Payment Form

Thank you for choosing our **Automatic Credit Card Payment Plan**.

The staff at Dermatology Specialists of Charlotte is continuously developing ways to help keep our patient's cost of receiving healthcare services to a minimum. This payment plan has been created to help you minimize your time and money spent writing and mailing checks, credit card numbers, etc. in order to pay your medical bills. Just submit your information one time and the rest of the work is left up to us! Your information will be kept secure and accessed only after we receive the Explanation of Benefits (EOB) from your insurance company giving us the remaining balance (if any) owed by you. Once your card has been charged, a receipt, along with your statement showing a zero due balance, will be mailed to your home address on file.

Please contact us if you have any questions at 704-943-3714 option 3.

Patient Name _____

Credit Card Holder's Name _____

American Express Discover MasterCard Visa (circle one)

Credit Card Number _____

Expiration Date _____ Security (CV) Code _____

By signing below, I authorize Dermatology Specialists of Charlotte to charge the credit card number I have provided for any and all outstanding patient portion balances.

Credit Card Holder's Signature _____

Date _____

When your credit card expires, and you receive a new one in the mail, please be sure to let us know the new expiration date, and any change in the account number. If you decide to cancel this plan, or if you want to change the credit card account that we use, please submit a written notice of cancellation immediately.