Dermatology Associates of Northen Kentucky, PSC

Credit Card on File Notification

Dear EXISTING Patient/Parent/Guardian:

RE: Dermatology Associates of Northen Kentucky Financial Policy

Effective June 1, 2024, our office policy for New Patients will now require a signature and credit card on file for no-show fees ($50 for office visit/$100 per site for procedures), balances due at the time of service (copays/deductibles/downpayments/ non-covered services) and balances remaining after the claim is resolved by your insurance plan. Please complete the attached form and thank you for your cooperation.

Frequently Asked Question

1. **When will my charge card be charged?** Your card will be charged either at time of service or once we receive notice from your insurance plan that there is a balance owed by you for services.

2. **How much will be charged to my credit card?** There is no fixed dollar amount. The amount you owe is deemed by your insurance plan and each insurance plan is different. We will only charge the amount deemed as your patient responsibility. In addition, your insurance plan is required by law to send you an Explanation of Benefits which indicates how your services were processed, paid for and the amount of your patient responsibility.

3. **Will you send me a notification that you made a charge on my credit card?** Yes, we will send you a notification along with an electronic receipt. Please ensure you provide us with your email address and cell number.

Dermatology Associates of Northen Kentucky, PSC

Credit Card Pre-Authorization

I _____ authorize Dermatology Associates of Northern Kentucky to keep my signature on file and to charge the credit card selected below for balances due at the time of service and balances remaining after claim (s) is (are) resolved. The authorization is for myself only _____ and all my dependents_____ who are patients of Dermatology Associates of Northen Kentucky, and this authorization is valid until I provide you with written cancellation.

I understand that I will receive an electronic receipt as notification of payment.

Please List Dependents' Names and Date of Birth:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Credit Card No: _____

Name on Card: _____

Expiration Date: _____

Security Code: _____

_____ _____

Patient/ Credit Card Holder Signature Date