Skin Oasis Dermatology

Credit Card Policy

Initialing indicates that you have read and understand each policy

_____ I understand it is company policy that additional service fees will be charged based on non-payment of co-pays at time of service, late cancellation of appointments, no shows **(medical $100 fee and cosmetic service 30% deposit)** and other polices of the Practice which may change from time to time without notice.

A monthly billing surcharge will be added to subsequent statements for all balances **not paid within 30 days** of the date of the first statement. I further understand that a fee **($40)** will be added to subsequent statements for returned checks. A fee for medication management telephone calls will be charged.

Medical appointments = 48 hours (2 full business days) notice
Cosmetic appointments = 72 hours (3 full business days) notice

Medical Appointment

_____ I understand it is company policy that we will charge your credit card the late **cancellation fee and/or "no show" fee** of **$ 100** if you fail to cancel your appointment 48 hours prior **(2 full business days)** to your appointment time or if your appointment has been missed. Please list your valid credit card information below, as well as your signature authorizing the charge. We keep all files confidential and assure your personal information will not be shared.

Cosmetic Appointment

_____ I understand that there is a **30% deposit** for all COSMETIC PROCEDURES, payable when scheduling an appointment/checking-in. Please provide a **72 hour (3 full business days) notice** if you need to cancel the appointment. **Your deposit is non-refundable if our office does not receive a 72 hour cancellation notice.**

Credit Card Type: MC, Visa, AMEX, Discover, Care Credit (circle one)

Card Number _____ **Expiration Date** _____

CVC Code_____ - **Zip Code** _____

I, _____ hereby authorize ***Skin Oasis Dermatology*** to charge my card the fee of **$100** in the event I **"no show"** for a scheduled appointment or I fail to cancel an appointment **48 and/or 72 hours prior**, or to pay any fees owed for services.

After insurance claims have been processed, **remaining balances such as copays, deductibles and co-insurances will be charged to the credit card on file**.

Signature_____ **Date**_____