COSMETIC DERMATOLOGY & SURGERY PC

CREDIT CARD AUTHORIZATION FORM

Date_____

I _____ understand Cosmetic Dermatology & Surgery, PC's policy on "no show" and cancelled appointments. By signing this document I understand my credit card will be charged if I "no show" or cancel without advance notification.

General Appointments:

If I cannot make it to my appointment, I must notify the office 24 hours in advance. No-shows and cancellations not within 24 hours will be charged $50.00 for the missed appointment.

_____INITIAL***

Surgery/ Procedure Visits /Cosmetic Procedure Appointments:

For surgery appointments, I need to cancel before 48 hours of the appointment. No-shows and late cancellations within the 48 hour window will be charged $125.00 for the appointment. _____INITIAL***

Appointment Length:

Standard appointments are 15 minutes long. If I am more than 15 minutes late I understand I may be asked to reschedule. This will ensure that all patients receive the time they deserve for their appointment.

If I have multiple problems I understand the provider will try to address the most pressing issue and may schedule me for another appointment to address other concerns. _____INITIAL***

Telephone Visits - Patient acknowledges that they may schedule a telephone appointment with the practitioner, which is approximately 10 minutes in duration. The patient will be called by Dr. Panine and adjustments made to prescriptions or treatment plans as needed. Patient's credit card will be charged $55 on the day the telephone visit is completed. _____INITIAL***

CREDIT CARD TYPE _____

CREDIT CARD #

_____

EXPIRATION DATE_____ 3 or 4 digit code : _____

BILLING ADDRESS_____

_____

BILLING ZIP CODE_____

NAME ON CARD _____

(As it appears on card)

_____ _____

SIGNATURE DATE