Mahoney Dermatology Specialist, P.A.

7995 66th Street North

Pinellas Park, Fl 33781

Patient Credit Card on File Agreement

All credit card information will remain confidential and encrypted and will not be released to any unauthorized party. We have implemented a policy which maintains credit card information securely and encrypted on file with eClinicalWorks, our HIPPA Compliant Electronic Medical Records Software. You will be asked for a credit card at the time you check in. By providing Mahoney Dermatology Specialists, P.A. with your credit card information, you are giving Mahoney Dermatology Specialists permission to automatically charge your credit card on file to pay co-pays, deductibles and balances you owe after your insurance company has paid their portion and notified us of the amount that is your responsibility. You will receive a **statement via email** that will indicate the amount due, and **we will deduct that amount from your card 7 days later**. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. Within those 7 days, you can call and change your method of payment if you wish.

I hereby authorize Mahoney Dermatology Specialists to charge the credit card provided on file with eClinicalWorks on behalf of Mahoney Dermatology Specialists, P.A. on an as needed basis for the amount(s) due for service(s) that are the patient responsibility amount as determined by insurance. I further authorize that any time my account becomes past due Mahoney Dermatology Specialist's, P.A. may use this card to settle the debts owed on my behalf. Any overpayments on my account will be credited back to my card or in the form of a check. My credit card statement will serve as a receipt for payments that have been processed. I may request a copy of my receipt by contacting Mahoney Dermatology Specialists, P.A (Telephone: 727-530-0920) and a response will be sent to me via email or US mail. This document designates my Signature is on File and therefore is not required that I sign paper receipts each time my credit card is processed. This authorization is to remain in effect until Mahoney Dermatology Specialists receives written notification from me of its termination. If my credit card information listed below changes for any reason, I will notify the billing department at Mahoney Dermatology Specialists as soon as possible.

Signature: _____Date: _____

Patient Name Printed: _____

If you think your charges are incorrect, please contact the billing department with an explanation of the problem. We will make any necessary adjustments to your account within 30 days. After 60 days all charges will be assumed to be correct. Contact information: (727)530-0920