# Lehigh Valley Dermatology Associates

940 N New Street
Bethlehem, PA 18018

# Credit Card Authorization Form

FOR USE **ONLY** ON BALANCE DUE ACCOUNTS

## Patient Information

Patient Name: _____

Credit Card Holder's Name: _____
(as it appears on the card)

Credit Card Holder's Address: _____

Phone Number: (_____) _____-_____

## Payment Information

Type of Credit Card: ____ Visa ____ MasterCard ____ Discover
16 Digit Card Number: _____
Expiration Date: (___/_____) 3 Digit Security Code: _____ (on back of card)

## Payment Information

$_____.___ ____ One-Time Charge ____ Monthly ____Weekly

I authorize Lehigh Valley Dermatology Associates, to charge my personal credit card listed for the amount authorized above for the balance due on my account. I agree to pay the amount which has been explained above. I understand that Lehigh Valley Dermatology Associates will not process this payment until this original form is signed and a copy of my picture ID is received by our practice. I agree to allow the amount due to be processed on the credit card listed above and understand I will be charged any fees incurred from charge backs in addition to my balance due to our practice. Any unpaid balance is subject to collections processes. Your credit card will be stored on file for new patient accounts and will be destroyed after your first appointment. It is the patient's responsibility to contact us with your method of payment for any balance owed to the practice. We require you to fill out this credit card authorization form each time we process a credit card payment.

Card Holder Signature: _____Date: ____/_____/_____

Please mail this completed form to: Lehigh Valley Dermatology Associates
940 N New Street
Bethlehem, PA 18018
Attn: Patient Accounts

____ I request for Lehigh Valley Dermatology to mail my receipt(s) to my billing address when my balance is zero.