17560 South Golden Road, Suite 100, Golden, Colorado 80401

Credit Card On File Authorization

I, the undersigned, authorize and request Hill Center for Dermatology, PC to charge my credit card on file for balances due to services rendered that my insurance identifies as my financial responsibility.

This authorization relates to:

- ☐ Co-payments only
- ☐ All payments not covered by my insurance company for services provided by the Hill Center for Dermatology, PC
- ☐ Payment Plan amounts as previously arranged

This authorization will remain in effect until I cancel it. To cancel, I must contact Hill Center for Dermatology, PC.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Maximum Charge Amount Allowed Per Transaction: $_____

Cardholder Name: _____ Signature: _____

Billing Address: _____

City _____ State _____ Zip_____

Credit Card Number: _____

Expiration Date: _____/_____ CVV Code: _____