PREMIER DERMATOLOGY

AUTO PAY AUTHORIZATION

As a convenience for our patients, we have developed a method for you to keep your credit card information on file with PREMIER DERMATOLOGY in order to simplify the payment process. By enrolling in this payment program, you authorize Premier Dermatology to initiate payments of your account balances from your designated account.

PREMIER DERMATOLOGY reserves the right to change these terms or terminate this program at any time. These terms do not in any way terminate, amend or modify other terms, agreements or policies that apply to your relationship with PREMIER DERMATOLOGY or the services provided to you.

Credit/Debit Card

Name on card_____

Account Number _____

Expiration Date _____ Security Code _____

Maximum Amount $_____ (not to exceed $200)

Email address _____(required)

Terms

By completing this enrollment in Auto Pay I agree to the following terms.

____I authorize PREMIER DERMATOLOGY or its agent to automatically initiate payment as listed above. I agree to be bound by any rules that my credit card issuer requires for pre-authorized debit or credit card transactions. I understand that I am responsible for all fees charged by my financial institution.

____I acknowledge that payment will be initiated when charges for services are below the Maximum Amount I have selected. This authorization remains in effect until my payment method fails, or I make changes to the agreement. I understand that I have the right to terminate my authorization at any time by contacting PREMIER DERMATOLOGY.

____**I acknowledge that I will be notified of charges above the maximum amount and will need to initiate payment for these charges separately from my Auto Pay Enrollment.**

____I acknowledge that it is my responsibility to maintain an active payment method for my Auto Pay enrollment to remain active. If a payment fails due to an inactive or expired payment method, I may be unenrolled from Auto Pay and will be notified of the need to remit payment.

____I acknowledge that I will receive electronic communications, such as Auto Pay notifications and receipts at the email address provided. These communications will contain payments details and will list the name of entity I am paying.

Name _____

Patient's Signature _____Date _____