c h i c a g o
COSMETIC SURGERY AND DERMATOLOGY

Name: «Person_First_Name» «Person_Last_Name»
Patient ID: «Person_ID»

515 N State St. ● 9th Floor ● Chicago, IL 60654
P 312-245-9965 ● F 312-245-9964 ● chicagodermatology.com

CCSD Credit Card Authorization Policy

As you know if you ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or car rental company since it makes checkout easier, faster and more efficient.

We would like to make it simple for you to pay for any services that are your responsibility. We require a credit card on file for all services that are billed to your insurance company. We accept Visa, MasterCard, Discover or American Express. **If you are not aware of your insurance benefits, Including your deductible and coinsurance amounts, please contact your carrier. If you have a high deductible plan, it is recommended that you provide a credit card as opposed to a debit card.** We do everything possible to maximize your insurance benefits.

This policy will be advantageous to you since you will no longer have to write and mail us a check for your balances. This also will have a positive effect on the environment. This payment process will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

As we continue to strive to protect the security of your personal information, your credit card information is encrypted to CCSD employees. Your credit card information is stored in a high-security system that goes beyond Payment Cared Industry (PCI) compliance using Point-to-Point Encryption (P2PE) which involves a combination of secure devices, applications, and processes that encrypts the card data from the first interaction at the point of sale up until the data reaches the secure payment processing environment.

If you have any questions about this payment method, do not hesitate to ask.

Credit Card Information:

Name of Patient: _____ (Last) _____ (First) _____ (MI)

Name of Cardholder: _____ (Last) _____ (First) _____ (MI)

Card Type: ☐ Visa ☐ MC ☐ Amex ☐ Discover Expiration Date: _____

Credit Card Number (last four numbers only): _____

Billing Address (Required):_____

Phone Number: _____

Authorized Signature: _____ Date: _____

I authorize Chicago Cosmetic Surgery and Dermatology, LLC (CCSD) to securely maintain my credit card account information and to charge my account in full for any outstanding balances after my insurance carrier has processed my claim(s). I agree to inform CCSD of any changes regarding my credit card account number and/or expiration date. This authorization will remain in effect until revoking in writing by the cardholder which will apply to future dates of service only. There will be at $35.00 fee for non-sufficient funds.

I read, understand and agree to this policy. (Parent or guardian complete if patient is a minor).

_____ Print Name _____ Signature _____ Date

Welcome to CCSD

1. Office visit and/or procedure occurs.

2. Financial responsibility determined and collected at Check Out.

3. Your insurance provider processes your claim.

4. All insurance adjustments and payments are applied to your claim.

5. Balance/credit, if any, applied to credit card on file.

Please contact your insurance provider if you are unaware of your deductible and/or co-insurance amounts. Please don't hesitate to call our insurance and billing staff at 312-245-9965 ext. 108 or 103 if you have any questions.

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