CHERRY CREEK DERMATOLOGY PC, CREDIT CARD AUTHORIZATION FORM Date_____

I _____ understand Cherry Creek Dermatology, PC's policy on "no show" and cancelled appointments. By signing this document I understand my credit card will be charged if I "no show" or cancel without advance notification.

General Appointments:

If I cannot make it to my appointment, I must notify the office 24 hours in advance. No-shows and cancellations not within 24 hours may be charged $50.00 for the missed appointment. This fee will not be covered by the insurance company. _____INITIAL***

Surgery Appointments:

For surgery appointments I need to cancel before 48 hours of the appointment. No-shows and late cancellations within the 48 hour may be charged $125.00 for the appointment. This fee will not be covered by your insurance company. _____INITIAL***

Appointment Length

Standard appointments are 15 minutes long. If I am more than 15 minutes late I understand I may be asked to reschedule. This will ensure that all patients receive the time they deserve for their appointment.

If I have multiple problems I understand the provider will try to address the most pressing issues and may schedule me for another appointment to address other concerns. _____INITIAL***

Electronic Recording

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within this office. _____INITIAL***

CREDIT CARD TYPE _____

CREDIT CARD # _____

EXPIRATION DATE _____

BILLING ADDRESS _____

_____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

_____ _____
SIGNATURE DATE