1331 w. 75TH Street, Unit 402, Naperville, IL 60540
P: 630.596.8045 **F:** 630.590.9634

CREDIT CARD INFORMATION RETENTION POLICY

Thank you for providing us with your insurance information. Claims for your services will be filed promptly and payments will be applied to charges for today's services. You may have noticed that the changing healthcare market has created an increase of financial responsibility being shifted to the patient. This has resulted in patient balances, high deductibles, uncovered services, increased copays and co-insurances. For this reason, we, as many other physician practices, are adopting new financial policies that will create more efficient and convenient resolution of patient balances.

As a convenience to our patients, we ask that you provide us with your credit card information. This information will be kept in a **confidential and secure file** (once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization).

We are committed to following the strict rules and guidelines established by HIPAA to ensure that your privacy is protected and we maintain strict standards to safeguard your credit card information as required under the Payment Card Industry Data Security Standard (PCI DSS). This convenient protocol will allow you to pay for the portions of your services that are not covered by your insurance plan in an easy and secure manner. **In the case of overpayments, refunds will also be processed automatically.** Charges for your visit/ treatment will be submitted to your insurance company. We will send you an invoice and wait 30 days for payment. If payment is not received after 30 days, we reserve the right to charge your credit card for the balance due. We will give you a courtesy phone call prior to charging your credit card. We will obtain verbal authorization for any patient accounts higher than $200.

Please complete the following:

Patient name: _____________________________ Patient date of birth:__________________

Account guarantor (if other than patient): ____

□ I authorize ***Basko Dermatology*** to keep my credit card on file with the understanding that charges will be processed for charges not paid by my insurance. The credit card will be used as a convenience to pay for patient balances as determined by my insurance company.

Signature ____Date _____________________