Hecker Dermatology Group, PA

CREDIT CARD AUTHORIZATION FORM

Date_____

I _____ authorize **Hecker Dermatology Group, PA** to charge my credit card for services rendered, not covered, or made my responsibility based on my insurance carriers explanation of benefits that is sent to me as a patient and sent to Hecker Dermatology Group, PA for claims adjudication.

CREDIT CARD TYPE _____

CREDIT CARD # _____

CARD CV2 # _____

EXPIRATION DATE _____

BILLING ADDRESS _____

_____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

_____ _____
SIGNATURE DATE

_____ _____
HECKER DERMATOLOGY GROUP, PA REPRESENTATIVE DATE

DO NOT WRITE BELOW. FOR COMPANY USE ONLY.

NOTES: _____