advanced DERMATOLOGY
A FOREFRONT DERMATOLOGY PRACTICE

Chart # _____

CREDIT CARD ON FILE AGREEMENT

_____ _____

Patient Name (Please Print) Date of Birth

Forefront Dermatology, S.C., d/b/a Advanced Dermatology, a Forefront Dermatology Practice will keep your credit card on file as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, co-insurance or other unpaid balances. Your credit card information will be kept confidential and secure.

- Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility. **30 days following insurance response any unpaid balances will be charged to the credit card on file.**
- **All cosmetic treatments and co-pays must be paid at the time of service or will be charged to credit card on file.**
- **If a medical concern is addressed during a cosmetic appointment, a separate medical evaluation and management service may be billed and submitted to insurance, when applicable.**
- **A $35.00 fee may be assessed to your account for returned checks or for loss of funds related to a credit card dispute.**

CANCELLATION POLICY:

- **MEDICAL PATIENTS:** We require at least 24 hr notice to cancel or reschedule a medical appointment. A $25 fee will be charged to the credit card on file for a cancellation or reschedule of less than 24 hours' notice, and $50.00 for a No Show.
- **COSMETIC PATIENTS:** We require at least 72 hr notice to cancel or reschedule a cosmetic appointment. A $50 fee will be charged to the credit card on file for a cancellation or reschedule of less than 72 hours' notice and $100.00 for a No Show.
- **LATE ARRIVAL:** All patients who are more than **10 minutes** late for their appointment will need to be rescheduled.

PLEASE NOTE: A CREDIT CARD IS REQUIRED ON FILE AND MUST BE PRESENTED AT CHECK-IN FOR SWIPE

We accept cash, checks, Visa, MasterCard, Discover, American Express, Care Credit, Apple Pay, and Patient Fi

I certify that I have been informed of and accept the Credit Card on File policy.
I authorize Forefront Dermatology, S.C., or its agent, to charge my credit card any outstanding balances as noted above.
This authorization will remain in effect until revoked by me in writing.

Date ___/___/___ _____

Signature of Patient (or Legal Representative)

_____

Signature of Patient Service Representative

Effective: 3/1/2026