**Allison J. Stocker, MD, PA and/or Skin by Design Dermatology & Laser Center, PA**

*Effective 01/2006*

**FORM MUST BE COMPLETED OR A $50.00 DEPOSIT IS REQUIRED WITH EACH VISIT**

To my patients,

In order to improve office efficiency, we will no longer send bills for balances not paid by your insurance company. Your insurance company should send you the explanation of benefits.

We now require a credit card to guarantee payment of any outstanding balances. This will greatly improve office efficiency in that we will no longer have to generate and mail a bill, and you will no longer have to write and mail a check.

Your credit card information will be held securely until your insurance has paid their portion. At that time, any remaining balance owed by you will be charged to your credit card. A copy of the charge will be mailed to you.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays and deductibles will still be due at the time of your visit.

A notification of balance will be mailed to your address and in 3 business days the amount will automatically be charged to the credit card listed below.

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

Sincerely,
Allison J. Stocker, MD, PA

I authorize Allison J. Stocker, MD, PA and/or Skin by Design Dermatology & Laser Center, PA to charge any outstanding balance(s) on my account to the following credit card:

**American Express • Debit card • Discover • Mastercard • Visa**

**Account #:**_____**Expiration date:**_____

**On reverse indicate the 3 digit code:**_____ **Your billing zip code:**_____

**Name on card (Please print)**_____

**Signature:**_____**Date**_____

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**When paying by check:** When you provide a check as payment, you authorize us to use the information from your check to withdraw the amount from your account or to process the payment as a check transaction. Information from your check will be made available for the withdrawal. Funds may be withdrawn from your account as soon as the same day you make payment.

I understand that in the event that my check payment is returned for insufficient funds, I expressly authorize my account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. By using my check I acknowledge and accept this policy.

Signature:_____

516 Lexington Ave.• San Antonio Texas, 78215-1906