LAKEWAY DERMATOLOGY

Skin Cancer, Cosmetic & Laser Center

Auto Bill Pay
(optional)

Patient Name: _____ Date of Birth _____/_____/_____

Parent/Guardian Name (if applicable): _____

Some of our patients find it convenient to leave a credit card number on file so that their out-of-pocket balances can be charged automatically.

We will only charge the portion designated by your insurance company as "patient responsibility" after your claim has been processed.

Once we process any charges, a receipt will be mailed to you.

Please automatically charge:

_____Full Balance Due

_____Balances of $50 or less

Card Holder Name: _____

Billing Address: Street _____ State _____ Zip _____

Credit Card Number: _____

Expiration Date: ___/___

Security Code: _____

(3 digit code on back of MC®/Visa®/Discover® or 4 digit code on front of Amex®)

Signature: _____ Date _____/_____/_____