NORTHAMPTON
Dermatology
ASSOCIATES

Credit Card Authorization Form

I authorize Northampton Dermatology Associates P.C. to charge my credit card for any balances after insurance payment to the card indicated below. I understand that my card will not be charged any amount in excess of $200.00. I understand that charges exceeding $200.00 will be billed to me directly and not be charged to my card automatically.

Credit Card Type:

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Credit Card Information (Please print clearly)

Account Number ____________________ Expiration Date ____________________

Authorization of Card Use

Cardholder Name ____________________

Signature ____________________ Date ____________________

Please send me a receipt for charges applied to my card: ☐

Northampton Dermatology Associates, 190 Nonotuck St., Suite #107, Florence, MA 01062 t: 413 586 5798 f: 413 585 0587