SIGNATURE DERMATOLOGY
3853 TRUEMAN COURT
HILLIARD, OH 43026
(614) 777-1200

ELECTRONIC FUNDS TRANSFER (EFT) FORM

I hereby authorise that all future payments be made via Electronic Funds Transfer to the following credit card account:

APPLICANT DETAILS
Name:
Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Security Code: ____ ____ ____ **Expiration Date:** ____ ____ **/** ____ ____

PAYMENT PLANS
I authorize Signature Dermatology to charge me $_____ on the _____ of every month for _____ months.

Conditions of this agreement:

I authorize Signature Dermatology to charge the credit card indicated in this authorization form according to the terms outlined below. This credit card will be used for any remaining balance that is patient responsibility. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. If payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

☐ I prefer to have my account charged once my Explanation of Benefits (EOB) reflects patient responsibility

-or-

☐ I prefer to wait 30 days until after my statement date to charge my account

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☐ I would like a copy of my receipt mailed to me –or- emailed to me at: _____

SIGNATURE: _____ DATE: _____