SUTTON PLACE
DERMATOLOGY

Daniel R. Foitl, MD
445 East 58th Street
New York, NY 10022
Phone (212) 838-0270 Fax (212) 753-5329

Credit Card Authorization Form

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):
CVV Code:

I,_____, authorize Sutton Place Dermatology, PC to charge my credit card above for payment of any **deductibles/co-pays/co-insurance** that is deemed my responsibility as per my insurance plan. I understand that my information will be saved on file for future transactions on my account which may include **cosmetic services and/or non-medically necessary** services.

I, _____understand that Sutton Place Dermatology, PC will mail a monthly bill to my home prior to charging my credit card. The credit card on file will be charged in the event there is no payment after 30 days.

_____ _____

Customer Signature Date