KRAUSS DERMATOLOGY

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
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I, _____, authorize Krauss Dermatology to charge my credit card above for agreed upon services, procedures and purchases. I understand that my information will be saved to file for future transactions on my account.

I understand I will be charged a $75 no show fee if I fail to cancel my appointment less than 48 hours in advance.

This completed form must be emailed to cosforms@kraussderm.com or faxed to 781-416-3505 prior to your scheduled appointment.

_____

Patient Signature & Date

Madeline Krauss, M.D. ● Pamela Norden M.D. ●Ellen Lacomis M.D.
Michael Bosworth, M.D. ● Deborah Goddard, M.D. ● Jessica Suzanne Mosher M.D.
1 Washington Street, Suite 401 Wellesley Hills Ma 02481
Phone: 781-416-3500 Fax: 781-416-3505