PEDIATRICS, LTD.

Credit Card on File Agreement

Is this a health savings or flexible savings account? Yes ☐ No ☐

Name on Card (print): _____

Last Four Digits of Credit Card Number: _____ Exp. Date: _____

Please fill out information below for all patients you authorize this credit card for:

Patient's Full Name (print): _____ DOB: _____

Patient's Full Name (print): _____ DOB: _____

Patient's Full Name (print): _____ DOB: _____

Patient's Full Name (print): _____ DOB: _____

At check-in, your credit card information will be obtained and kept securely until your insurance has paid its portion and notifies us of the balance due, if any. You will then be sent a statement which you will have 14 days to review and pay your balance. After 14 days, if the balance remains unpaid, we will bill your credit card. Copays are always due at the time of service.

This does not compromise your ability to dispute a charge or question your insurance company's determination of payment. If there is a discrepancy that you would like to dispute, please contact your insurance company.

By signing below, I authorize ABC Pediatrics, Ltd. to keep my signature and my credit card information securely on-file for my account. I authorize ABC Pediatrics, Ltd. to charge my credit card for any outstanding balances when due.

If the credit card provided changes, expires, or is denied for any reason, I agree to immediately provide ABC Pediatrics, Ltd. a new, valid credit card. Even though ABC Pediatrics, Ltd. is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card provided.

For Balances Over $15

☐ Mail Statement - Run card in 14 days if payment is not received prior

- ☐ Email receipt to _____
- ☐ No receipt

☐ No Statement - Run Credit Card Immediately after claim is processed with insurance

- ☐ Email receipt to _____
- ☐ No receipt

Credit Card Holder's Signature: _____ Date: _____

***** Please Note *** Balances under $15 will be charged immediately**