CREDIT CARD ON FILE AUTHORIZATION FORM

Credit Card on File Policy:

At Advanced Pediatrics, we require keeping your credit or debit card on file as a convenient and secure method of payment for any portion of services that your insurance does not cover but for which you are responsible. Your card information is kept confidential and securely stored. Payments are processed only after the claim has been submitted to your insurance. Your insurer has processed the claim, and the insurance-covered portion has been paid and posted to your account.

Authorization:

I, the undersigned, authorize Advanced Pediatrics to charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization applies to all unpaid amounts for services provided to the patient(s) listed above.

This authorization will remain active until I provide written cancellation with 60 days' notice, and the account is in good standing.

Responsible Party Information:

Signature: _____ Date: ____ / ____ / _____

Relationship to Patient(s): _____

Card Information:

Card Type: Amex ☐ Visa ☐ Mastercard ☐ Discover ☐

Cardholder Name: _____

Credit Card Number: _____ CVV:_____ Expiration Date:_____

Office Staff Use Only:

Account #: _____