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CREDIT CARD ON FILE POLICY

As a condition to providing treatment, Premier Pediatrics, PLLC requires you to provide a valid credit card number to keep on file in order to secure payment for the portion of services that your insurance company will not cover, but for which you are responsible.

Your credit card information will be kept confidential and secure and only authorize staff will have access to the information as necessary to manage your account balance. Your supplied credit card will be charged only under the following circumstances:

1. After your claims have been processed by your insurer, and your insurance company determines your responsibility for any amounts due for the services you have received.
2. For all current patient balances, including co-pays, deductibles, co-insurance and charges not allowed by your insurance company.

Authorization:

I authorize Premier Pediatrics, PLLC to charge the portion of my bill that is my financial responsibility to the following credit card:

Amex Visa Mastercard

Name on Credit Card: _____

Credit Card Number: _____

CVV Code: _____

Expiration Date (MM/YY): ____/____

Billing Address: _____

I, the undersigned, authorize and request Premier Pediatrics, PLLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Premier Pediatrics, PLLC. This authorization will remain in effect until I cancel this authorization. To cancel, I must give 60-day notification to Premier Pediatrics, PLLC in writing and the account must be in good standing.

Date: _____

Client Name (Print): _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____