Credit Card on File

CREDIT CARD ON FILE AUTHORIZATION	
In order to ensure payment of any patient responsibility balances and/or any fees acquired, we require a valid credit card be kept on file with the practice. Your credit card information will be kept confidential and secure and will only be processed for charges you agree to in the credit card agreement.	
□ Missed Appointment Fee	□ Balances up to $_____
□ Co-pay/Deductible at Time of Visit	□ Other _____
I authorize The Pediatric Place to keep my credit card information on file to charge any fees accumulated due to missed appointments and, at my request, co-pays, deductibles, and balances. I am aware that I will be charged a 2.99% credit card transaction fee for each transaction and that should I choose to avoid this fee, I can make payments via cash or check in a timely manner. I also understand that a receipt can be provided at my request. This authorization shall remain in effect until I cancel this authorization.	
Patient Name:	
Cardholder's Name:	
Card Number: Exp: CCV:	
Cardholder's Signature:	
Date:	
□ I decline to keep a credit card on file with The Pediatric Place. I understand that by doing so, it is my responsibility to make sure any fees and/or balances are current at all times and that if they are not, I am subject to being declined services due to these outstanding balances or fees acquired.	
Printed Name:	
Signature:	
Patient Name:	
Date:	