Pediatric Associates of Mt. Carmel, Inc.

Established 1972

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Patient(s):

_____

_____

_____

Parent/Guardian/Self:

_____

Date: _____

I state that I have no active insurance coverage and agree to the following terms and conditions as a Self-Pay patient/family at Pediatric Associates of Mt. Carmel.

- A credit card will be required to be kept on file with our secure merchant.
- A minimum payment of $75 will be required at the time of services if the balance is not paid in full.
- If you decide to pay in full, you may receive a discount.
- If not paid in full, you will be required to agree to one of the following agreements (A or B). Please initial the option you choose:

_____ A. The credit card on file will be charged a minimum of $75.00 on the first Friday of the month if the balance does not exceed $450.00. If your balance exceeds $450.00, our billing department will call you to discuss.

_____ B. The credit card on file will be charged the full outstanding balance on the first Friday of the following month.

The credit card number is securely stored on a remote server with our merchant provider. Only the last four digits of the card are visible to our office. This agreement does not affect your right to dispute any charges.

Parent/Guardian/Self Signature: _____

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By signing below, you agree to keep a credit card on file with Pediatric Associates of Mt Carmel and authorize this card to be charged.

VISA *MASTERCARD* *AMEX* *DISCOVER*

Name on Card: _____ Last 4 digits of CC#: _____

Email for Receipt: _____

Phone Number: _____

Signature of Authorized User: _____Date: _____

❑ Check if you prefer not to receive a statement in the mail

SHRED AFTER ENTERED INTO SECURE MERCHANT PROVIDER

Credit Card #: _____ Exp Date:_____/_____3 Digit Code (4 for Amex):_____

Batavia
2055 Hospital Drive
Suite 250
Batavia, Ohio 45103

Eastgate
4371 Ferguson Drive
Cincinnati, Ohio 45245
(513) 752-3650

Landen
4834 Socialville-Foster Road
Suite 50
Mason, Ohio 45040