Hartford Area Pediatrics, P.C.
Thomas Binder, M.D.   Meredith Barrows, M.D.
Colleen Gerrity, M.D.   Matthew Serna, M.D.
21B Arts Center Court Avon, CT 06001
Phone 860-678-9400 – Fax 860-678-9480

Card on File/Financial Agreement

I allow Hartford Area Pediatrics to keep my HSA or credit card information on file. I give my consent for Hartford Area Pediatrics to charge my credit card:

___ **for the full balance reflected on my child/children's account(s) when a balance is due.**

___ **payments in the amount of $____________ (amount to be no less than $40.00 per month), to be paid towards the monthly balance on my child/children's account(s), until the balance has been paid in full.**

Please list the name(s) of the child/children this agreement shall include:

Name: ____ **DOB**_______________________

Name: ____ **DOB**_______________________

Name: ____ **DOB**_______________________

Name: ____ **DOB**________________________

I understand that there is no finance charge or interest imposed under this agreement. A receipt of payment will be available online or via email.

____________________________________ ___________________________
Credit card number CVV **Expiration Date**

____________________________________ ___________________________
Guarantor/Responsible Party Name (Print) **Relationship**

Signature ______________________________ **Date** _______________________