BEACON PEDIATRICS

CREDIT CARD AUTHORIZATION FORM

For your convenience, you may use a credit card to pay for your child's services here at Beacon Pediatrics.

This credit card authorization covers payment for _____.
(patient name)

I, _____, give Beacon Pediatrics,
(name of card holder)

permission to charge my credit card. I understand that my credit card number will be kept on file to cover copays, co-insurance, deductibles, no show/late cancellations, and any out of pocket expenses that may occur that are not covered by insurance.

Please read and initial:

_____ I understand that payments are due and charged at the beginning of each visit.

_____ I understand that I will not be notified prior to my credit card being charged.

_____ I understand that I will receive a Paid Statement of Receipt by mail if my card is charged.

_____ I understand that my card will be stored in a way that is HIPAA compliant; either in a locked file, a password protected and encrypted computer or an electronic health system.

_____ If the card holder is not the patient, cardholder agrees that Beacon Pediatrics can charge this credit care in the manner described above for the patient named above.

_____ I understand that my signature authorizes Beacon Pediatrics to charge my credit card in the manner described above.

CREDIT CARD INFORMATION																		
Card Type: ❑ Master Card ❑ Visa ❑ Discover																		
CREDIT CARD #:																		
Expiration Date: ____/____ **Security Code: _____** **Cardholder Zip Code: _____**																		

_____ _____

Signature **Date**