PEDIATRIC ASSOCIATES MEDICAL GROUP, INC.

PRACTICE LIMITED TO INFANTS, CHILDREN, AND ADOLESCENTS

CREDIT CARD AUTHORIZATION FORM

Pediatric Associates requires that a valid credit card be kept on file for all its patients. This is a convenient method of payment for the portion of services that your insurance does not cover, but for which you are responsible.

Co-pays are due at the time of service.

Your card information is stored confidentially and securely within our HIPAA compliant Electronic Medical Record and Billing System and only viewed by authorized staff.

By signing below and providing your credit card information, you are authorizing Pediatric Associates Medical Group, Inc. (PAMG) to automatically charge your credit card for any balance put into "patient responsibility" as result of your insurance plan's deductible, co-insurance, co-payment, and non-covered services. This payment will be processed only after the claim is filed, processed, and finalized by your insurance carrier, and we received a copy of the Explanation of Benefits (EOB) from your insurance plan. At that time, you will be sent a statement for the balance due. After 30 days, if the bill remains unpaid, we will bill your credit card for the balance.

You agree to update any information regarding this credit card. If the credit card that you provide changes, expires, or is denied for any reason, you agree to immediately give PAMG a new and valid credit card which you will allow them to charge over the telephone. You agree that the new card may be used with the same authorization as the original card.

Your right to dispute a charge or question your insurance company's determination of payment will remain unchanged. We will work with you to resolve any issues and will refund you if we have made a billing error. Our Billing Department can be reached at (818) 784-1102 Ext 3. If you disagree with how your insurance carrier processed the claim you will need to contact their customer service department directly.

You understand and agree that this form is valid until you give a 30-day written notice to cancel the authorization to Pediatric Associates Medical Group, Inc.

By signing below, I, _____, certify that I am an authorized user of this card and authorize Pediatric Associates Medical Group, Inc. to keep my signature and my credit card on file. I authorize PAMG to charge the card listed below for outstanding balances due.

Patient's Name: _____ **Date of Birth:** _____

Card Holder's Name (as shown on card): _____

Signature of Card Holder: _____ **Date:** _____

Credit Card Number: _____ **Exp. Date (MM/YY):** _____

Card Type: [ ] Visa [ ]Master Card [ ] HSA Card **NO AMEX or DISCOVER**

CVV Code: _____ **Billing Zip Code:** _____

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