Credit Card Automatic Payment Authorization Form

_____ (Initial) At the time of your visit, our policy is to collect any copay that may be due. If you have a deductible plan, we will collect a minimum amount, typically $100.07 on average, which we estimate to be your responsibility for the visit. Afterward, we will submit a claim to your insurance.

By signing this form, you authorize Crossroads Pediatrics, PLLC to charge your Visa, MasterCard, American Express, or Discover card for any remaining balance owed after we receive the explanation of benefits from your insurance company _____ (Initial)

Maximum pre-authorized charge amount per visit; $101.00 _____ (Initial)

The charge will appear on your credit card statement and the receipt will be emailed to you.

Patients Last Name_____ First Name_____ Date of Birth_____

Card Type (circle): Visa Mastercard American Express Discover

Card Cardholder Name (as shown on card): _____

Card Number_____

Expiration Date (mm/yy)_____/_____ Security Code (on back of card):_____

I hereby authorize Crossroads Pediatrics, PLLC to charge my card for services provided to the patient listed above. I understand that my payment information will be securely saved on file for future transactions on my child's account.

Signature_____ Date: _____