Credit Card Automatic Payment Authorization Form

_____ (Initial) At the time of service it is our policy to collect any copay due. If you have a deductible plan, we will collect the minimum amount (average $59.03-$64.45) that we expect to be your responsibility at the visit. A claim will then be sent to your insurance.

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

_____ (Initial) Maximum pre-authorized charge amount per visit; $75.00 (we will call to get permission before charging your card for anything remaining balance higher than $75.00.)

_____ (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 rendered to the patient above. I understand that my information will be saved and kept on file for future transaction on my child's account.

Signature_____ Date: _____