LONE STAR PEDIATRICS

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME: _____ **PATIENT NAME:** _____
PATIENT NAME: _____ **PATIENT NAME:** _____
PATIENT NAME: _____ **PATIENT NAME:** _____

The purpose of this form is to authorize *Lone Star Pediatrics* to retain a valid credit card number on file for you as our patient. **All self-pay patients are required to complete this form. All custodial parents who want the non-custodial parent (or another party) billed for charges are required to complete this form.** This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. reserves the right to charge the credit card listed below for all current patient balances (see "note" below).
2. If you miss a scheduled appointment without a 3-hour notice to cancel or reschedule, LONE STAR PEDIATRICS reserves the right to charge the credit card listed below $75.00 for our standard no-show fee. *As a courtesy, a representative from LONE STAR PEDIATRICS will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24-hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct telephone number on file & an active voicemail box to leave messages.*
3. If we receive notice from the bank that a payment is returned to us for any reason, LONE STAR PEDIATRICS reserves the right to charge the credit card listed below a $25 insufficient funds fee plus the outstanding balance (see "note" below).

* *Note: All balances not paid in full at the time of service will incur a 20% interest fee after 30 days of non-payment.*

Other than the conditions mentioned above, under NO circumstance will LONE STAR PEDIATRICS charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:

Having read this form and talked with the billing office staff, my signature on the following page acknowledges that I voluntarily give my authorization to *Health Kids Pediatrics* to charge my credit card according to the conditions listed above and that I can call the office at any time to request a payment receipt.

LONE STAR PEDIATRICS

CREDIT CARD AUTHORIZATION FORM

Patient Name(s): _____
Account Number(s): _____
Street Address: _____
City: _____State:_____Zip:_____

DEBIT/ CREDIT CARD:

Credit Card Number: _____Exp Date:_____
Cardholder Name: _____CVV:_____
Billing address: _____

This authorization will remain in effect until cancelled by myself, *Lone Star Pediatrics* or my financial institution. I can cancel this authorization at any time by calling or writing to Lone Star Pediatrics using the information below. A $25 service charge will be applied to any returned payment and will not be waived. If further attempts at submitting a payment to your bank are unsuccessful you will be mailed one statement and will forfeit the prompt-pay discount as well as incur a 20% interest charge. You will have 45 days to resolve your outstanding account.

X Guarantor Signature: _____ Date: _____

OR

Refusal to Provide Credit Card Details:

Refusal to complete and agree to this authorization dictates the following:
The patient acknowledges that no prompt-pay discounts will be given without a valid card on file. Since there is no credit card on file with Lone Star Pediatrics, LSP reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice (this will include a 20% interest charge). It is your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and potentially having your account closed with our practice.

Signature of refusal: _____ ***Date:*** _____