PEDIATRIC NEUROLOGY PC

AUTHORIZATION FOR CREDIT/DEBIT CARD PAYMENTs

Dear Patient/Authorized person:

For your convenience, ***PEDIATRIC NEUROLOGY PC,*** accepts Visa, Master Card, Discover and Amex Cards. For both your and our protection, you must fill out and return this form to us.

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Patient & Card holder Information:

_____ phone (_____)_____
Patient's last name, first name

_____/_____/_____ _____ _____
d.o.b. Ins-1 Ins-2

_____ phone(_____)_____
Card holder's last name, first name

_____
Billing address (street)

_____
Billing address (City, State, Zip code)

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CREDIT/DEBIT CARD INFORMATION (front and back copy of credit/debit card with ID is requred)

_____ _____ _____ _____ -_____ _____ _____ _____ -_____ _____ _____ _____ -_____ _____ _____ _____ _____
Credit/debit card # Card type

_____/_____/_____ _____
Expration date CID code

CREDIT/DEBIT CARD INFORMATION (front and back copy of credit/debit card with ID is required)
(alternative)

_____ _____ _____ _____ -_____ _____ _____ _____ -_____ _____ _____ _____ -_____ _____ _____ _____ _____
Credit/debit card # Card type

_____/_____/_____ _____
Expration date CID code

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STATEMENT OF AUTHORIZATION

Patient/Card holder hereby authorizes ***PEDIATRIC NEUROLOGY PC*** to charge credit/debit card to receive payments for deductibles, co-insurance or other patient payments as indicated by Insurance, or lack thereof.

We have enclosed a photocopy of the above stated Credit/debit card(s) (front & back) and ID for proper verification of these transactions. We will updated ***PEDIATRIC NEUROLOGY PC*** upon the expiration date and/or other necessary information as the credit/debit card stated above is renewed.

By signing this document I/we am/are accepting all responsibility for these transactions to ensure full and proper payment to ***PEDIATRIC NEUROLOGY PC.***

_____ _____ _____/_____/_____
Name (print) Signature Date