

Village Pediatrics, LLC

Credit Card Authorization

I, _____, hereby authorize Village Pediatrics, LLC, to charge my credit card the balance of payment due Village Pediatrics, LLC after receiving notice from my insurance company. The amount charged is not to exceed the amount due. I also understand that I am responsible for payment of services should credit card be declined for any reason.

Village Pediatrics, LLC will send a receipt of the charges along with an explanation of benefits. These documents are to be used should the insurance company audit any claims filed by Village Pediatrics, LLC.

Name(s) of patients _____

Date of service _____

Name of cardholder _____

Cardholder signature _____

Credit card number _____

Expiration date _____

Security number (3digit code on back of card) _____

Should you decline to provide credit card information, payment in full is expected at the time of service.

Village Pediatrics, LLC (witness) _____

Signature _____