PEDIATRIC HEALTH CARE ALLIANCE P.A.

CREDIT CARD ON FILE AUTHORIZATION FORM

Please fill out the details as indicated below.

Card Holders Name:
(Exactly as it appears on card) _____

Card No: _____(Only the Last Four Digits of Card)_____

Expiration Date: _____ CCV2: (see below) _____

Card Type: Visa [ ] MasterCard [ ] Discover [ ] American Express [ ] HSA Card [ ] FSA Card [ ]

I hereby authorize Pediatric Health Care Alliance, P.A. to charge the credit card listed above for payment of any outstanding charges at the point of care, within 48 hours of each visit date. In addition, I hereby authorize Pediatric Health Care Alliance P.A. to charge the credit card listed above for any additional outstanding balances once they have received the Explanation of Benefits from my insurance carrier. I understand my Insurance Carrier will notify me with an Explanation of Benefits detailing the payment made and amount owed prior to PHCA P.A. receiving notification and processing my Credit Card on File. I hereby authorized PHCA P.A. to charge the credit card listed above for any additional outstanding balances on a monthly balance, to my account, up to the amount of $250. I understand that I will be notified by email on the day my Credit Card on File has been processed.

Card Holders Signature: _____

Date: _____

Please list your child/ children's name(s) and dates of birth:

_____

_____

_____

This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by emailing a written request to phcabillingoffice@pedialliance.com email address. _____ (initial here). A new application must be submitted if users credit card expires. The applicant must email a written notification to phcabillingoffice@pedialliance.com if the credit card is cancelled, lost, or stolen.

I authorize Pediatric Health Care Alliance, P.A. to keep my signature and card information on file in order to charge any services provided that remain outstanding. I understand my card information will be kept in a secure encrypted format _____ (Initial here)

I understand that this authorization is valid until canceled in writing as set forth above, with any questions regarding my account, my credit card, or any past due amount. My email address is _____. I understand that charges for ongoing services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each visit date. Additionally, I agree that the card listed above may be charged by Pediatric Health Care Alliance, P.A. in order to settle any outstanding balances. I understand that if a chargeback fee is incurred or a retrieval fee is incurred, I am responsible for these fees. _____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Pediatric Health Care Alliance, P.A. for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Pediatric Health Care Alliance, P.A. and those attempts have failed. _____ (Initial here)

I authorize Pediatric Health Care Alliance P.A. to contact me by telephone or email _____ (initial here)
For any changes, please contact: phcabillingoffice@pedialliance.com