

{Practice Name}

{Address Line 1}
{City}, {State} {Zipcode}
{Phone Number}

DATE

{Guarantor/Credit Card Holder Name}
{Guarantor/Credit Card Holder Address}
{G/CC City}. {G/CC State} {G/CC Zipcode}

{Patient Name #1}	{Patient #1 DOB}	{Patient Name #5}	{Patient #5 DOB}
{Patient Name #2}	{Patient #2 DOB}	{Patient Name #6}	{Patient #6 DOB}
{Patient Name #3}	{Patient #3 DOB}	{Patient Name #7}	{Patient #7 DOB}
{Patient Name #4}	{Patient #4 DOB}	{Patient Name #8}	{Patient #8 DOB}

This is to authorize {Practice Name} to charge my Credit Card as listed below in the following circumstances:

1. In the event my children are seen when accompanied by a nanny or other caregiver and I am not present to make payment arrangements, or
2. at the time an Explanation of Benefits (EOB) from my insurance carrier indicates that there are amounts owed to {Practice name} due to Co-Insurance or Deductible obligations under my insurance plan.

I agree to follow {Practice Name}'s Financial Policies regarding payment for services, including the addition of a \$3.00 service or transaction fee for payment by credit card. I understand that this fee may change from time to time at the sole discretion of {Practice name}.

This authorization is good until otherwise revoked in writing by myself or expiration of the credit card information listed below. Revocation of this authorization may be hand delivered to {Practice name} or mailed to {Practice Name} at the above address.

Credit Card #: _____ CCV: _____ (3 digit code on back)

Expiration Date: _____

Credit Card Holder Signature: _____

(Photocopy CC front and back below:)
