CENTENNIAL PEDIATRICS, PA

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Authorization to Charge Credit Card and/or Self Pay Form

Authorization to charge credit card:
I authorize Centennial Pediatrics, PA to charge the below listed credit card for any outstanding balances that is incurred for visits, treatments, and after hour nurse calls. I understand that Centennial Pediatrics will contact me by phone for transactions over $100 for my permission. Receipts will be mailed following any credit card transaction. Credit card information will be kept secure and confidential.

Self-Pay:
Patient(s) that **do not** have insurance will be considered Self Pay patients. Please note that the Self Pay visit cost may not be the only cost you have during your visit. If additional test and/or shots are given, you will be charged for these at checkout. So please make sure you ask the nurse first if any additional test/shots are covered

Patient's Name ________________________DOB_______

Patient's Name ________________________DOB_______

Patient's Name ________________________DOB_______

Patient's Name ________________________DOB_______

I understand that this authorization will be valid thru the expiration of my credit card, unless I cancel this authorization through written notice.

- ☐ MasterCard
- ☐ Visa

____
Cardholder Name

____
Billing Address, City, Zip

Account Number_______________________Expiration Date __________________

Signature____ Date_______________

Insurance information is due no later than 10 days from the date above. If information is not received or insurance does not show valid/active, your card will be charged for the entire visit. You will then have to file the claim on your own w/the Insurance Company.

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