HAPPY DAYS PEDIATRICS

Credit Card Authorization

All information will remain confidential

In adherence to our clinic's policy, we ask each patient to keep credit/debit/or HSA card on file for any copays or outstanding balances from our clinic. **You will be notified by our staff of any charges made to your account.**

I, _____(print name as it appears on the credit /debit/ or HSA card), authorize Happy Days Pediatrics to submit any charges for professional services including copays, guarantor balance fees that are rendered to _____(print full legal name of patient receiving services) to my credit/ debit/ HSA card. This authorization will also apply to future outstanding charges, and to future added credit/debit/ HAS cards if this one becomes no longer active.

Name on Card: _____

Credit Card Type: _____ Visa _____ MasterCard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Security Code: _____ (last 3 digits located on the back of the credit card)

Amount: **Will be your Ins. Copay at the time of service/ or a balance on a prior visit that will be applied towards either your co- insurance or your deductible.**

I authorize Happy Days Pediatrics to charge the amount listed above to the credit card provided herein.

I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____ Date: _____

Print Name: _____

List all children in the family whose balances, copays, or co-insurances this card will also be used for.

1._____ M/ F DOB: _____

2._____ M/ F DOB: _____

3._____ M/ F DOB: _____

4._____ M/ F DOB: _____

5._____ M/ F DOB: _____