

# Bethesda Pediatrics

## CREDIT CARD ON FILE AUTHORIZATION FORM

Patient Name(s):

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Responsible Party Name:

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Relationship to Patient:

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Phone Number:

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### Purpose of Card on File

Bethesda Pediatrics requires all new patients to keep a valid credit card on file. This card will be used only for:

- Missed appointment fees, including the \$50 fee for physical exams or conference appointments not canceled or rescheduled at least 24 hours in advance
- Any additional missed appointment fees as outlined in our Office Policy
- Returned check fees, if applicable

Your card will not be used for co-pays or routine balances unless you request it. Your information is stored securely in our encrypted payment system.

### Credit Card Information

Card Type: Visa \_\_\_\_ Mastercard \_\_\_\_ AmEx \_\_\_\_ Discover \_\_\_\_

Name on Card: \_\_\_\_\_

Card Number:

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Expiration Date (MM/YY):

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Billing Zip Code:

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## Authorization

I authorize Bethesda Pediatrics to charge my credit card for missed appointment fees and other applicable fees as described above. This authorization will remain in effect until I provide written notice of cancellation.

Signature of Responsible Party:

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Date:

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