PATIENT CREDIT CARD AUTHORIZATION

DOWNERS GROVE PEDIATRICS
6840 MAIN STREET
SUITE 201

630-852-4551(OFFICE)
630-852-0131 (FAX)
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In an effort to better serve our patients and simplify your billing experience, our practice offers credit card acceptance. Charge card information is filed with your confidential patient information and kept secure.

_____ (initial) I hereby authorize DOWNERS GROVE PEDIATRICS to charge the balance currently due on my account to pay balance in full if not paid within 30 days of last statement.

PAYMENT INFORMATION

Patient Name: _____

Patient Billing Address: _____

_____

Type of Card: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Last 4 digits: _____

Expiration Date: _____ Security Code: _____
(last three digits on card, last four on AMEX)

The undersigned guarantees performance of the financial provisions of this agreement.

Card Holder Name: _____

Signature of Card Holder: _____ Date: _____

CHARGE POLICY

_____ (initial) Being the authorized cardholder, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. If credit card on file is declined, we will make one attempt to get new credit card information. If we do not have a resolution within in 48 hours of being contacted, your account will immediately be turned over to collections.