Card on File Agreement

We are committed to making payment as convenient as possible for our patients. By signing below, you agree to keep your credit or flex spending card ("Card") on file with us as a convenient method of payment for any patient responsibility portion of charges not covered by the patient's insurance company. The Card will be kept on file and will be utilized until the expiration date on the Card or until this authorization is revoked in writing. You may revoke this credit card authorization at any time by submitting a written request to billing@pmpediatrics.com and providing an alternate form of payment for services.

The Card may be utilized for payments made at the time of today's visit or future visits, such as patient "copays," in addition to being used for any open balance on the patient account. Once we receive the explanation of benefits documentation from the patient's insurance company, the Card will be charged for any remaining balance which is the responsibility of the patient, and we will send a confirmation email to the email address on file with the patient's account.

Your Card information will be kept confidential and electronically secure within our practice's credit card processor. **For your protection, office personnel will not have access to your card and only a portion of your card number will be displayed in our electronic medical record system.** Note that by using a credit card to pay for medical services, you are forgoing state and federal protections regarding medical debt (including, prohibitions against wage garnishment and property liens, prohibitions against reporting medical debt to credit bureaus and limitations on interest rates). Medical bills paid by credit card are no longer considered medical debt.

Please contact billing@pmpediatrics.com or 516-869-0650 x305 with any questions.

Acknowledgment

I, the undersigned, acknowledge the contents of this Card on File Agreement. I am an authorized user of the Card and authorize the practice to keep my Card on file and charge the portion of any bill that is the financial responsibility of the patient identified below.

Patient Name: _____ Patient Date of Birth: _____

Cardholder Signature: _____

Cardholder Name: _____

Date: _____