Required Authorization for automatic credit card payment

Payment is expected when services are provided. Parents are jointly responsible for payment of their children's account.

Co-payments

We will bill any and all amounts to the credit card indicated below for any co-payments that are not paid in full on the date of service. Co-payments of less than $25.00 will be assessed a $5.00 administrative fee for this service.

Unpaid balances over 90 days

We will bill any and all amounts to the credit card indicated below for all balances over 90 days old. Balances of less than $25.00 will be assessed an administrative fee of $5.00 for this service.

Waivered services

We will bill any and all amounts to the credit card indicated below for services that we provide for which you have signed a waiver. Waivered services typically include those that are not paid by insurance, or "optional" services that may be partially paid by insurance.

Finance charges

We may charge you either 1 ½ percent per month or the maximum allowed by law on any and all unpaid balances.

Notification

We will notify you by first class mail of any charges, including those we have applied to your credit card, within 30 days. Notification by first class mail will be sent to the address you have provided. If you do not receive monthly statements from us, it is your sole responsibility to inform us by contacting our business office. Failure to receive a statement does not relieve responsibility for payment.

Authorization:

By your signature below, indicate your understanding and acceptance of the terms and conditions outlined herein.

I authorize Rose City Pediatrics Medical Group to prepare, submit, and collect any and all amounts on my child(ren)'s account as outlined above, by charging all amounts to the credit card number I have provided below. This agreement will automatically renew at the expiration date of the credit card, and remain in force until all amounts on linked accounts are paid or my/our children are no longer patients of Rose City Pediatrics Medical Group, whichever comes later. This agreement does not preclude other legal or collections action of any type.

VISA ____ ____ ____ ____- ____ ___ ____ ____- ____ ____ ____ ____- ____ ____ _____ _____ EXP:_____

M/C ____ ____ ____ ____- ____ ___ ____ ____- ____ ____ ____ ____- ____ ____ _____ _____ EXP:_____

By _____ Relationship: ___mother ___father ___legal guardian
Signature

Print name:_____ Date_____