Credit Card Authorization

Thank you for choosing Randolph Pediatrics for your child(ren's) healthcare needs.

We are committed to providing you with exceptional care, as well as making our billing process as efficient as possible. Randolph Pediatrics requests that all patients keep an active credit card on file. Your card information will be kept confidential and secure.

- Complete the credit card authorization below and return form to the office via patient portal or in person
- Please indicate if this is an HSA account card.
- Balances under $150 will automatically be charged to the credit card on file.
- For balances over $150, please indicate below the max allowed to charge.

Name of Patient(s): _____

Visa or Mastercard

Name on Card: _____

Credit Card # to be kept on file _____Expiration Date: _____

MAX ALLOWED OVER $150.00 $_____
HSA CARD? YES___ NO___

I, the undersigned, authorize and request Randolph Pediatrics to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Randolph Pediatrics in writing and the account mut be in good standing.

Card Holder's
Signature_____Date_____

Your insurance will be billed for all visits, and upon determination of benefits, all patient responsibilities will be subject to billing. All co-pay and outstanding balances require payment at the time of service. Overdue balances requiring a second mailed statement will incur a $5.00 administrative fee. Missed or canceled appointments, without 24-hour notice, will be subject to a fee of $50.00.

*Billing Policies are subject to change.