____ _________________________

Patient Name Date of Birth

Integrative Developmental & Behavioral Pediatrics, LLC

CREDIT CARD ON FILE POLICY

We require that we keep your credit or debit card on file as a method of payment for unpaid office visits, video appointments, medical form completion, and missed appointments.

Your credit card information is kept confidential and secure. You will be notified by telephone about any charges that may result from a missed appointment, form completion, returned check fees, or other service that was not provided in person. Charges will be processed either immediately after speaking with you, or no sooner than 48 hours after leaving a voicemail on the number you provided for appointment confirmation, whichever is sooner.

I authorize Integrative Developmental and Behavioral Pediatrics to charge the following credit or debit card for services provided:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover ☐ Other________________________________

Credit Card Number ____

Expiration Date _____ / _____ / _____

Security Code__________(3 digit # on back of card for Visa/MC/Discover, 4 digit code on front of card for Amex)

Cardholder Name ____

Signature ____

Billing Address ____

City ____ State_______ Zip _______________________

I (we), the undersigned, authorize and request Integrative Developmental and Behavioral Pediatrics to charge my (our) credit card, indicated above, for services rendered.

This authorization relates to all payments for services provided to me by Integrative Developmental and Behavioral Pediatrics. Another method of payment may be substituted at the time of service, if desired.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification in writing to Integrative Developmental and Behavioral Pediatrics, and the account must be in good standing.

____

Patient or Patient's Representative Name (Print)

____

Patient or Patient's Representative's Signature

Date_____/_______/_______