Pediatric Practices of Northeastern Pennsylvania

1837 Fair Ave.	27B Woodlands Drive	510 Routes 6 & 209	62 Industrial Park Road
Honesdale, PA 18431	Waymart, PA 18472	Milford, PA 18337	Lake Ariel, PA 18436
Voice: 570-253-5838	570-488-9550	570-296-4901	570-689-7565
Fax: 570-253-6678	570-488-9553	570-296-5480	570-689-4803

Credit Card On File Authorization

To Our Patients:

Thank you for choosing our practice for your healthcare needs. In order to provide the best service we must be responsible for the financial side of our practice as well. To make this easier, you will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be emailed to you.

This will be an advantage to you, since you will get fewer letters and statements from us and you will no longer have the hassle of writing and mailing us checks. This also cuts down on things like paper, printing , postage which keeps the cost of health care down and is environmentally healthier.

This is similar to when you check into a hotel or rent a car, the first thing you are asked for is a credit card, which is entered into their system and later used to pay your bill. This is good for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

Credit card payments will be processed on the third Friday of each month. A bill will be sent out to you at least 10 days beforehand to make you aware that your card is being used for the payment. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Effective November 1, 2013 **any accounts that need to be billed** will have an additional $15 billing fee applied. To avoid this charge, you can provide us with payment at the time of service and provide credit card or checking account information to pay any balances after the insurance company's determination. If your insurance requires no deductible, co-insurance or if you always pay your copayment at the time of service, this billing fee will not affect you.

If you have any questions about this payment method, do not hesitate to ask us.

Sincerely yours,

Pediatric Practices of Northeastern PA

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Authorization

Until further notice I, _____ authorize Pediatic Practices of Northeastern PA to charge the patient-responsible balances on my account to the following credit card:

Circle One: Visa Mastercard Discover American Express

Credit card #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ . Exp. Date (mm/yy): __ __ / __ __

or Checking Account:

Routing #: __ __ __ __ __ __ __ __ __ Acct #: __ __ __ __ __ __ __ __ __ __ __ __

Voided Check or Deposit Slip (for savings accounts) attached below.

We will enter your card information into the secure credit card processing website. Thank you.

Signature: _____ Date: _____

Printed Name: _____

Email address: _____

Address of Cardholder/Acct Holder: _____

_____

Phone Number of Cardholder/Acct Holder: (_ _ _) _ _ _ - _ _ _ _

(Attach Check or Deposit Slip here)

For office use only:

Guarantor PCC# _____

Patient PCC# _____

Billing ID#_____ Acct Flagged: y n

Confirmation # _____ (circle one)