

*Pediatric Practices of Northeastern Pennsylvania*

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1837 Fair Ave.  
Honesdale, PA 18431  
570-253-5838

27B Woodlands Drive  
Waymart, PA 18472  
570-488-9550

396 Routes 6 & 209  
Milford, PA 18337  
570-296-4901

62 Industrial Park Road  
Lake Ariel, PA 18436  
570-689-7565

Credit Card On File Authorization

To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted 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.

We now have a similar policy. 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. You can also request a paper copy from the receptionist at check-out.

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.

Credit card payments will be processed on the third Friday of each month. We will remind you 10 days beforehand 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 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 Pediatric 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): \_\_\_\_ / \_\_\_\_

Three digit security code (on the back of the card): \_\_\_\_

(front of Card for AE)

or Checking Account:

Routing #: \_\_\_\_\_ Acct #: \_\_\_\_\_

Voided Check or Deposit Slip 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 )

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For office use only:

Guarantor PCC# \_\_\_\_\_

Patient PCC# \_\_\_\_\_

Billing ID# \_\_\_\_\_ Acct Flagged: y n

Confirmation # \_\_\_\_\_ (circle one)