Credit Card Authorization Consent Form

This consent authorizes Pediatrics Association of Avon to keep your credit card information and signature on file for the purpose of charging your credit card for services rendered. You understand that this authorization will remain in effect beginning on the "Start Date" indicated and ending on the "End Date" indicated (for a period of one year) or until you cancel it in writing, and you agree to notify Pediatric Associates of Avon in writing of any changes to your account information. You certify that you are an authorized user of this credit card and will not dispute these transactions with your bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

PATIENT INFORMATION

Patient Name: ____ DOB: __________
Patient Name: ____ DOB: __________
Patient Name: ____ DOB: __________
Patient Name: ____ DOB: __________

AUTHORIZATION LIFETIME

Start Date:* _______________________ End Date:* ______________________
Must be one year from Start Date

CARD HOLDER INFORMATION

Card Holder First Name:* ____
Card Holder Last Name:* ____
Billing Address (Street):*____
City:* ____
State:* ____
Zip Code:* ____

Card Type:* ☐Visa ☐Mastercard ☐Discover ☐American Express
Card Number:*____
Expiration Date:* ____
Security Code:* ____

ELECTRONIC RECEIPTS

Email Address Where We Can Send Receipt(s):* ________________________

Signature:*_______________________________________ Date:* ______________

Printed Name: ___________________________________ Relationship: _________