PEARLAND PEDIATRICS
& SPORTS MEDICINE

PATIENT EASY PAY CONSENT

I authorize Pearland Pediatrics to charge my credit card for any patient responsibility amount after claims are submitted and processed by my insurance. These balances may include:

- Patient copay
- Deductible/HSA Deductible
- Any unpaid balance over 60 days

By signing below, you acknowledge and agree with the following:

- I have received and read the Pearland Pediatrics Financial Policy and agree to the terms.
- I agree to provide and allow Pearland Pediatrics to charge my HSA debit/credit card or personal credit card provided upon receipt of my insurance EOB.
- I understand Pearland Pediatrics will not have access to my full credit card number once it is entered into the system the first time.
- If the balance due is more than $200.00, I will receive a courtesy call prior to my card being charged.

Patient Name	Patient Date of Birth

______________________________ ________________________________ ______________________
Cardholder's Name Email Address Phone Number

____ ____________________
Cardholder Signature Today's Date

Internal Use Only

☐ Card Swiped

PCC Guarantor#____________