

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.
- Account statements or billing letters may be sent via USPS and/or messages through the patient's portal.
- This agreement shall remain valid until such time as written notice of cancellation is provided by the cardholder.

| Patient Name | Patient Date of Birth |
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| _____ | _____ | _____ |
| Cardholder's Name | Email Address | Phone Number |

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|----------------------|--------------|
| _____ | _____ |
| Cardholder Signature | Today's Date |

Internal Use Only
 Card Swiped Guarantor PCC # _____