

ONGOING CREDIT CARD CHARGE AUTHORIZATION
FOR MAIN STREET PEDIATRICS, LLC

I hereby authorize Main Street Pediatrics, LLC to retain my credit card information and authorization noted below, and to charge the credit card for any deductibles, coinsurances, copayments or other services rendered to/for the persons listed below. Charges are to be entered only for those balances due that are not covered by insurance. A copy of the credit card receipt and an account statement will be sent to the patient/guarantor with each charge.

Credit card charges are authorized for the following Main Street Pediatrics' patients:

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Type of Credit Card: MC VISA DISCOVER

ACCOUNT NUMBER: _____

SECURITY CODE ON CARD: _____

EXPIRATION DATE: _____

NAME ON CREDIT CARD: _____

RELATIONSHIP TO PATIENTS: _____

ADDRESS OF CARDHOLDER
ON CREDIT CARD ACCOUNT: _____

AUTHORIZING SIGNATURE: _____

DATE OF SIGNATURE: _____