SILVERDALE PEDIATRICS

CREDIT CARD AUTHORIZATION

Patient Name: _____ Date of Birth: _____ I understand that appointments will not be scheduled until all forms have been read, completed, and signed, and a credit card is on file to secure the appointment time. The card provided will be used for the appointments, deductibles, and non-covered services or fees. I understand that this card will not be charged unless I no-show, am late, cancel, or for other reasons as stated in the Office Policies and Procedures that I have read and agreed to abide by.

I hereby authorize SILVERDALE PEDIATRICS LLP, Saad Al-Agba MD, and Niran Al-Agba MD, to charge the following described Credit Card and have been duly informed of the policies and procedures as they were outlined to me in the Office Policies and Procedures. I hereby am aware of the treatment and charges and agreed to assume financial responsibility. I understand that this form is valid until I provide written notice that it is revoked. I also understand that if I change credit cards, I will supply Silverdale Pediatrics the new credit card information. I further authorize Silverdale Pediatrics LLP., to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (check one): ☐ Visa ☐ MasterCard

Card Number: Exp: (____ /_____)

Name on Card: CID (last 3 on back):

_____

Billing address:

_____

Patient Signature: (or financially responsible party)

_____ Date: _____