Pediatrics & Urgent Care

107 N Maclay Ave. San Fernando CA 91326
Phone 818-697-8585 Fax 888-799-8585

Credit Card Authorization Form

I understand that using my insurance benefit does not guarantee full payment, and by signing this form, I agree to pay *Pediatrics & Urgent Care* the full balance of my bill for the office visit and procedures provided to me today.

I, the undersigned, authorize *Pediatrics & Urgent Care* to charge or debit my credit card on file for all outstanding balances due for the visit and services that I and those whom I am financially responsible for received, after my insurance is processed.

I am financially responsible and agree to pay for the outstanding charges for the following people who received services at this medical clinic: _____

_____

(please write full names and dates of birth)

_____

_____

Last 4 digit of your Credit Card number: _____
Expiration Date: _____

_____ _____ _____

Print Name Signature Date