The purpose of this form is to authorize Manhattan Valley Pediatrics to retain a valid credit card number on file for your family. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information. Your supplied credit card will be charged only under the following circumstances:

1. Manhattan Valley Pediatrics reserves the right to charge the credit card listed below for all current patient balances, including co-pays, deductibles, co-insurance and charges not allowed by your insurance company. A receipt will be emailed to the email you provide. This notice serves as your consent to being charged for all current patient balances under $100 (one hundred dollars). Our office will contact you if any changes are over $100.
2. If you are not able to keep an appointment, we would appreciate 24-hour notice. There is a charge of $50 for a missed well appointment.

I agree and accept having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

Initial:________

Please circle type of card: Credit / HSA / HRA FSA Brand: Visa / Amex / MC
Patient name/s:____
Name on Card____
Credit card number:____
Expiration Date:___________________ Security Code:_____________________
Email:____________________________Mobile:___________________________