Pediatric Center of Round Rock
Caring for the future by taking care of the present

AUTHORIZATION FOR CREDIT CARD ON FILE PAYMENT

Patient Name: ________________________________DOB: ____________________

All card processing activities and related technologies utilized by Pediatric Center of Round Rock will comply with the Payment Card Industry Data Security Standard (PCI-DSS) in its entirety. No activity may be conducted nor any technology employed that might obstruct compliance with any portion of the PCI-DSS.

Credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the software system the first time.

AUTHORIZATION

Until further notice, I authorize Pediatric Center of Round Rock to charge the patient- responsible balances on my account to the card on file.

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Pediatric Center of Round Rock may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $75.00, I will receive a courtesy call prior to my card being charged.

Printed Name of Parent or Guardian______________________________________

Signature of Parent or Guardian____________________**Date**______________

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