Pediatrics East of New York
1015 Madison Avenue,
New York, N.Y. 10075
Tel: (212)-879-7014 Fax: (212)-628-8147

Credit Card Authorization Form

Dear Member,

As you know, there are charges for each of the medical services that are provided for you and your child. The co-payment, deductible, and co-insurance amounts that we are obligated to collect from you are determined by the benefits that your health insurance policy provides. This also applies to any non-covered services which our physicians provide to you which may not be covered by your insurance carrier. These benefits and responsibilities are designated by your healthcare provider and not by this office. For this reason we are often unable to determine what responsibilities you may or may not have towards the services provided at the time of service.

Since this office is not always privy to the details of your individual policy, we must hold you, the member, ultimately responsible for payment of all medical services provided for your child. This includes the presentation of your current and correct insurance coverage at the time of service as well as correct primary care physician designation.

In providing the information below you authorize payment by credit card for those charges determined as your responsibility for any balance on your account in excess of 60 days. This includes any co-payment, deductible, co-insurance, or any other charges assigned by your health insurance carrier. If the credit card information on file is not valid and the account is not addressed, the outstanding balance will be subject to an in-office late payment fee and will be subject to third party collections. Authorizing a new card to placed on file will allow this office to use that card for subsequent payments.

This office will make every effort to work with you in regards to your balance and any concerns you may have. We value you as as member of our practice and appreciate that you have entrusted us with your health-care needs. We ask only that you, as the member, also appreciate the care and services provided on your behalf by our physicians. We also ask that you please update your contact and credit card information if any changes have taken place.

Patient's Name: _____
Cardholder's name: _____
Email address: _____
Please note that we take only Visa or Mastercard at this office.
Credit Card No: _____- _____-_____-_____
Expiration Date: _____
Cardholder's Signature:_____ Date:_____

Office Patient Account Number: _____ (Office use only)