Columbus Pediatric Associates

CREDIT CARD AUTHORIZATION

Patient(s): ____

Account Type: ☐ Visa ☐ Mastercard

Account Number: ____

Expiration Date: _________________

CVV2 (3 DIGIT NUMBER ON BACK OF Visa/MC) ________________

☐ This is a debit card

☐ This is a credit card

Cardholder Name: ____

Billing Address: ____

City, State, Zip: ____

Cardholder authorizes the Office to charge an amount not to exceed: $_________ for transactions within the Physician's Office, including but not limited to lab fees and co-pays or Physician Services performed in a hospital or outpatient facility.

You may incur overdraft charges and other fees if your credit card or debit card is tied to your bank account(s). The Physician's Office shall not be responsible for any costs, fees or charges, including but not limited to any overdraft fees resulting from any medical expenses charged pursuant to this Authorization.

This authorization shall remain in effect until revoked by a written and signed notice from Cardholder. You may revoke this Authorization at any time by providing us with a written notice. Our office address is Columbus Pediatric Associates 1800 10th Avenue Suite 100-F, Columbus Ga. 31901. We cannot accept such notices via email or our website.

AGREED TO AND ACCEPTED BY THE CARDHOLDER

SIGNATURE OF CARDHOLDER: ____

DATE: ________________, 20____