Dear Parent,

We value you as a patient and appreciate that you have entrusted us with the healthcare needs of your child.

As you know, there are charges for each of the medical care services that we will provide for you. The co-payments, deductibles, and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are ultimately responsible for payment of the medical services provided to your child, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided.

Your health benefits, including your responsibility for co-payments, deductibles, and co-insurance are a decision made by your employer, not this office or your health plan.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but not limited to, co-payments, deductibles, and/or uncovered services).

Patient Name_____

Name as it appears on the credit card_____

Card Type: Visa MasterCard American Express

Card Number_____ Expiration Date_____

Security Code _____ Billing Zip Code _____

Signature_____ Today's Date_____