CENTENNIAL PEDIATRICS, PA

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Authorization to Charge Credit Card

I authorize Centennial Pediatrics, PA to charge the below listed credit card for any outstanding balances that is incurred for visits, treatments, and after hour nurse calls. I understand that Centennial Pediatrics will contact me by phone for transactions over $100 for my permission. Receipts will be mailed following any credit card transaction. Credit card information will be kept secure and confidential.

Patient's Name _____DOB_____

Patient's Name _____DOB_____

Patient's Name _____DOB_____

Patient's Name _____DOB_____

I understand that this authorization will be valid thru the expiration of my credit card, unless I cancel this authorization through written notice.

- ☐ MasterCard
- ☐ Visa

_____
Cardholder Name

_____
Billing Address, City, Zip

_____ _____
Account Number Expiration Date

Signature_____ Date_____

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