Pediatric Psychological Associates PLLC

DEBIT / CREDIT CARD AUTHORIZATION FORM

Parent/Guarantor(s) Name: ____

Patients Name: ____

I authorize Pediatric Psychological Associates (PPA) to keep my signature on file and to charge my payments or *other fees incurred *(late cancel/no show appointments) to the credit card listed below. Please call our office at (502) 429-5431 if you have any questions.

I understand that I may still pay for appointments on the day services are rendered by cash, check or credit card. In the event that I do not provide a form of payment on the day services are rendered, I understand that the below listed credit card will be charged.

I understand that if my health insurance company denies a claim or service that is first subject to a deductible or copay, I am responsible for the fees and my credit card will be charged.

□Visa® □MasterCard® □Discover® □American Express®

Credit Card Number: ____ **Expiration Date:** ______________

3 Digit PIN # on back of card: ____

Exact Name on Card: ____

Billing Address for Credit Card: ____

City: ______________________________________**State:**_________________________**Zip:**________________

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Signature of Cardholder **Date**

____
Phone Number of Cardholder

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