

 **CREDIT CARD AUTHORIZATION FORM**

At Desert Valley Pediatric Therapy, we bill special programs up front and may submit to insurances for reimbursement for families. However, to ensure payment for services, we require private pay clients to keep a debit, credit, or HSA card on file in our secure, HIPAA compliant system.

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| \_\_\_\_\_\_\_\_\_\_\_  | I enroll in auto-pay, and by doing so, authorize Desert Valley Pediatric Therapy  |
| (Initials)  | to charge my credit card, indicated below, to pay the balance due for services rendered and that my insurance company identifies as my financial responsibility.  |

**Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ CVV Number: \_\_\_\_\_\_\_\_\_\_\_ Billing Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, the undersigned, authorize and request Desert Valley Pediatric Therapy to charge my credit card, indicated above, for balances due for services rendered that have been identified as my financial responsibility. This authorization will remain in effect until I cancel this authorization. To cancel, I must contact the Desert Valley Pediatric Therapy billing office and the account must be in good standing.

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_