Credit/Debit Card Payment Authorization Form

At Sunshine Pediatrics, LLC, we are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients (except those with active Medicaid or Medical Assistance coverage), we ask that you adhere to our practice's credit/debit card policy, and agree to its terms, by signing below.

1. I agree to provide Sunshine Pediatrics, LLC, and/or its designated payment agent with my debit/credit card or ACH information.
2. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
3. If any amounts owed to Sunshine Pediatrics for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) deductibles and other amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or to provide timely notice of appointment cancellation, are not otherwise paid at the time of service, I agree and authorize Sunshine Pediatrics and/or its designated payment agent to apply charges to my payment card and/or ACH account for all those amounts owed to the practice.
4. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may

incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.

5. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
6. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
7. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____

Name as it Appears on Card/ACH Account Email Address

_____

Billing Address City State Zip Code

_____

Phone Number

AUTHORIZED SIGNATURE _____ DATE _____