busybeepediatrics™

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SIGNATURE AUTHORIZATION *(to remain on file)*

I have read and understand the Busy Bee Pediatrics, Inc. Credit Card on File policy and agree to allow Busy Bee Pediatrics, Inc. to bill my credit card for the portion of my child's medical care service that my insurance company does not pay.

Date: ____________________

Credit Card Authorization Information:

Credit Card Type: (Please circle) VISA MasterCard AMX Discover

Credit Card (Last 4 digits only) _____________________ Exp. Date: __________________________

Responsible party name (print): ____

Responsible party signature: ____

Phone (preferred): ____

Email address: ____

Address: ____

____

Billing Address (*if different than home address*):

____

Please add my Credit Card on File Authorization to the following Billing Profiles:

Name of Child/Dependent: _________________________________ Date of Birth: _________________

Name of Child/Dependent: _________________________________ Date of Birth: _________________

Name of Child/Dependent: _________________________________ Date of Birth: _________________

Name of Child/Dependent: _________________________________ Date of Birth: _________________

Name of Child/Dependent: _________________________________ Date of Birth: _________________

Other(s): ____ Date of Birth: _________________

□ *Please check here if any names added to backside of this page*

Cust. profile ID: ______________________
Office Use: