Westside Pediatric Clinic, PC

CREDIT CARD AUTHORIZATION

I authorize Westside Pediatric Clinic, PC to charge my unpaid co-payment, work-in charges and/or 60-day balances due under $100 to the credit card listed below. Any balance over $100 we are required to contact you to discuss payment terms.

This authorization will remain in force on each of my children's accounts until they are no longer patients of Westside Pediatric clinic, PC or until a written request by the cardholder instructing the practice to remove the authorization.

Please give your card to the Front Desk to be scanned into our secure system.

VISA MC DIS AMEX _____ _____

Please circle Last-4 Digits of Card Number Name on the Card

_____ _____

Cardholder Signature Date of Authorization

_____

Cardholder Email Address for all payment receipts

_____ _____ ____/____/____

Patient's Last Name Patient's First Name Date of Birth

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Patient's Last Name Patient's First Name Date of Birth

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Patient's Last Name Patient's First Name Date of Birth

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Patient's Last Name Patient's First Name Date of Birth

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4.2026 TRM