CREDIT CARD AUTHORIZATION FORM

At Desert Valley Pediatric Therapy, we bill for services at the end of each month and, for those who have commercial insurance, only after claims have been filed and processed by your insurer. Since we do not collect payment at the time of service, to ensure timely payment for services already rendered, we require private pay clients to keep a debit, credit, or HSA card on file in our secure, HIPAA compliant system.

Desert Valley Pediatric Therapy mails invoices at the beginning of each month. Your invoice reflects your financial responsibility for services rendered and is due by the 20th of each month. You have the option of paying with an alternative card/cash/check by the 20th of each. Your card on file will only be charged if you choose to enroll in our optional auto-pay program **OR** if we have not received another method of payment by the 25th of each month. Enrolling in our auto-pay program is voluntary; however, it allows you the convenience of paying your invoice each month without the need to call the office or mail a check.

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(Initials **Required**)

I understand that my invoice for services rendered is due by the 20th of each month. I authorize Desert Valley Pediatric Therapy to charge my credit card, indicated below, on the 25th of each month (or the previous business day) to pay the balance due as indicated on the invoice provided at the beginning of the month if I have not made other payment arrangements. I understand that if my balance is not paid in full by the 25th that services will be suspended until my account is in good standing.

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(Initials **Optional**)

I choose to enroll in auto-pay, and by doing so, authorize Desert Valley Pediatric Therapy 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. I understand my payment will be processed at the beginning of each month, and I will receive my invoice detail via email or mail with the amount charged and a reference number.

Credit Card Number: ____

Expiration Date: _____/ _____/ _____ CVV Number: ___________ Billing Zipcode:________________

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: _____ / _____ / _____