Acct # _____
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Lynn Keefe, MD
pediatrics

# Credit / Debit / HSA Card Authorization Form

This is our agreement with you to bill your credit or debit or HSA card for any balance on your account after your insurance claim is processed. It is your responsibility to update Lynn Keefe MD Pediatrics, LLC whenever a preferred and/or updated card is received.

| |
|---|
| **Patient Name:** |
| **Patient Name:** |
| **Patient Name:** |
| Credit/Debit/HSA Card Number: |
| Card Type: MasterCard Visa Discover AMEX |
| Cardholder Name (as shown on card): |
| Expiration Date (MM/YY): Billing Zip Code (from billing address): |
| Phone Number: |

I, _____ hereby authorize Lynn Keefe MD Pediatrics, LLC to charge this card for:

1. Any Co-pays, deductibles, coinsurance, and out-of-pocket amounts set by your Insurance company
2. Fees for services deemed non-covered by your insurance company
3. Fees for appointments missed or cancelled with less than 24-hours notice
4. Fees for returned checks or inaccurately disputed charge-backs subject to bank fee and an additional $25 fee

* There will be a $2.00 processing fee for each card transaction *

By signing below, I am authorizing Lynn Keefe MD Pediatrics, LLC to charge the account above for services rendered. I understand that this information will be stored securely for use in future transactions on my account. This form is valid until I cancel or update the authorization in writing. I understand that credit/debit/HSA card transactions require release of some of my identifying information and I consent to this release. I certify that I am an authorized user of the bank or credit card account and will not dispute the payment with my credit card company as long as the transaction corresponds to the terms indicated in this form.

_____ _____

Patient or Parent / Legal Guardian SIGNATURE DATE

Acct # _____
Acct # _____
Acct # _____