



EASY PAY AGREEMENT

This service will allow you to pay co-pays, deductibles, and balances easily and conveniently.

With this service you authorize Kids R Us Pediatrics to use this credit card as the form of payment for balances accrued, including lab test, co-pays, coinsurances, and deductibles.

What might my card be charged for?

Co-Pays: Co-pays are due at the time of the office visit.

Outstanding Balance: After your insurance provider has paid their portion of your bill [or any other patient you have listed on this form] if there is still an outstanding balance owed less than \$50.00, we will automatically charge the credit card on file, and mail you a statement and receipt of payment. For any balance over \$50.00, we will contact you for permission to charge the total amount or set-up payments with the card on file. This in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment. If your insurance company sends us a corrected payment at a later date, reducing your responsibility, we will refund or credit your account.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire on the expiration date listed below.** The card holder may revoke this consent at any time in writing.

Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express <input type="checkbox"/>
Credit Card Holder's Name: _____ DOB: ___ / ___ / ___ <i>(Please Print)</i>
Last Four Digits of Account Number: _____
Expiration Date: _____
Please fill out information below for any other person/s you authorize this credit card for:
Patient Full Name: _____ DOB: ___ / ___ / ___ <i>(Please Print)</i>
Patient Full Name: _____ DOB: ___ / ___ / ___
Patient Full Name: _____ DOB: ___ / ___ / ___

Credit Card Holder's Signature: _____ Date: _____

By checking this box I consent to the use of my e-signature on this form.