OLNEY PEDIATRICS, P.A.

Credit Card on File Authorization

I understand that I, the undersigned, am the authorized cardholder for the credit card indicated below and my signature below authorizes Olney Pediatrics to keep my credit/debit card on file. I understand that my credit/debit card will be processed immediately for copays. Balances of $80 or less will be charged automatically to my credit/debit card after 30 days.

____
Cardholder's Name

□ Swiped

____ Today's Date:_________
Cardholder Signature

Cardholder Email: _______________________________________

Patient(s) Name(s): ________________________________

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PCC account# (for office use) _______________

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Recurring Charge: I authorize regularly scheduled charges to my credit card. I will be charged the amount indicated below, each billing period. A receipt for each payment will be provided to me and the charge will appear on my credit card statement. I agree that no prior notification will be provided unless the date or amount changes, in which case, I will receive notice from us at least **10** days prior to the payment being collected.

I, _______________________, authorize Olney Pediatrics/BluePay to charge my Credit

Card for the Initial amount of $ ________ on (date) _________. And for the amount of

$________ for ________ payments on the 1st 15th of each month.

This payment is for the account # (for office use) _____________

____ _______________________
Signature Date

Rev 8/2020