1415 Wesley Drive
Salisbury, MD 21801
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forms@gatewaypediatrics.com

CREDIT CARD / HSA CARD ON FILE AUTHORIZATION FORM

Gateway Pediatrics, LLC accepts all patient payments via cash/check upfront at every visit or we will store your credit card information to be processed after your insurance's Explanation of Benefits (EOB) has been processed.

Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.

The undersigned agrees and authorizes Gateway Pediatrics, LLC to charge the credit card below for patient payments by the guarantor named below:

NAME AS IT APPEARS ON CARD____

LAST 4 DIGITS OF MY CARD NUMBER __ __ __ __

EXPIRATION DATE __ __ / __ __

BILLING ADDRESS____

BILLING CITY / STATE / ZIP____

PHONE NUMBER____

EMAIL (to send receipts)____

CARD TYPE _____HSA/FSA _____CREDIT _____DEBIT

I understand that once my insurance has paid for their portion of my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Gateway Pediatrics, LLC may charge my credit card on file for the balance due when they receive a copy of the EOB.

If the balance due is more than $200.00, I will receive a courtesy call prior to my card being charged.

AUTHORIZED SIGNATURE___________________________________ **DATE_____________**

Patients this card applies to:

NAME____ DOB_____________

NAME____ DOB_____________

NAME____ DOB_____________

NAME____ DOB_____________

Office Use Only
GR Acct No: _________________