AutoPay Authorization

I authorize Hamden Pediatrics, P.C. to charge my unpaid balance (co-payment, deductible, missed appointment fee, etc.) that is 30 days or more overdue for any amount under $____________ to the credit card listed below. For any balance over the specified amount, we will contact you for verbal permission before running the card.

I authorize Hamden Pediatrics, P.C. to charge my copay at the time of the visit. My copay is $______________

This authorization will remain in force on each of my childrens' accounts listed below until they are no longer patients of Hamden Pediatrics, P.C. or until written request by the cardholder instructing the practice to remove this authorization.

Please give your card to the Front Desk to be entered into our secure system. We do not store credit card numbers. The card will be swiped into our credit card processing platform and a token will be generated. We will use the token when charging your card for future payments.

Credit Card Information	
Card Type ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex	
Last 4 Digits of Card Number:	Expiration Date:
Cardholder's Name:	
Cardholder's Signature:	Date of Authorization:
Cardholder Email for all receipts:	

Patient's Name	Date of Birth
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

For Office Use Only: Token Number ______________________