Anshu Dalela, MD

White Cloud Pediatrics: Credit Card Authorization

To ensure timely payments, White Cloud Pediatrics requires a valid credit card on file. This form authorizes us to charge any outstanding balances, co-pays, and/or deductibles after your visit.

By signing, you agree to the following:

- **Credit Card on File:** I authorize White Cloud Pediatrics to securely store my credit card for future payments.
- **Payment Authorization:** I permit White Cloud Pediatrics to charge the card for any outstanding balances, co-pays, or unpaid fees.
- **Automatic Payments:** Payments will be processed after visits or when an invoice is issued. I will be notified of charges.
- **Declined Payments:** If my payment is declined, I agree to resolve it within 14 days to avoid service interruptions.
- **Privacy:** My credit card information will be kept confidential in accordance with HIPAA.
- **Revocation:** I can update or revoke my card details by notifying the office.

Authorization:

☐ I authorize White Cloud Pediatrics to keep the card below on file. **I understand that the Annual Administration Fee (AAF) will only be charged if I notify the front desk to authorize it. (See Financial and Office Policy for details.)**

☐ My card on file is **current** and may be used for charges.

☐ I **refuse** to provide a card on file and will ensure timely payment of balances.

Cardholder Name: _____

Billing Address: _____

Email: _____

Card Number: _____

Exp (MM/YY): _____ **CVV:** _____

Guarantor / Responsible Party's Name: _____

Guarantor / Responsible Party's Signature: _____ Date: _____