ISLAND KIDS PEDIATRICS, P.C.
Credit Card Pre-Authorization / ACH Pre-Authorization Form

I, _____ authorize Island Kids Pediatrics, PC to keep my signature on file and to charge the credit card selected below for balances due at the time of service and balances remaining after claim (s) is (are) resolved. This authorization is for all my children who are patients' of Island Kids Pediatrics and this authorization is valid until I provide you with written cancellation.

I, _____ authorize Island Kids Pediatrics to keep my signature on file and to initiate debit entries to my (*select one)* ☐**Checking Account or** ☐ **Savings Account** indicated below, at the depository financial institution named below, herein called DEPOSITORY, and to debit the following to such account for balances due at the time of service and balances remaining after claim (s) is (are) resolved. This authorization is for all my children who are patients' of Island Kids Pediatrics and this authorization is valid until I provide you with written cancellation.

Please Check one: ❑Visa® ❑ American Express® ❑ MasterCard® ❑ Discover Card®

Patient (s) Name: _____ _____

_____ _____

_____ _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____

Exp. Date: _____ CVV2/CVC2/CID #: _____

Cardholder Signature: _____**Date**: _____

ACH Pre-Authorization

Depository Name_____ Branch_____

City_____ State_____ Zip_____

Routing Number_____ Account Number _____

I also acknowledge that our paper check may be turned into an electronic funds withdrawal from our account and understand we will not receive our check back from our financial institution. I acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Name: _____
(Please print)

Signature: _____**Date**: _____

ISLAND KIDS PEDIATRICS, P.C.

2066 Richmond Avenue, S.I. ,NY 10314 TEL: 718-982-9001 FAX: 718-982-9008
2627B Hylan Blvd, S.I. ,NY 10306 TEL: 718-667-5500 FAX: 718-667-5510

Dear Parent/Guardian:

Re: Update for IKP Financial Policy

Effective **January 1st 2016**, it is our office policy for patients who have an insurance plan with a **patient responsibility** for copayments, deductibles, coinsurance or services not covered by your insurance; to keep your signature on file and to charge the credit card on file for balances due at the time of service and balances remaining after the claim is resolved by your insurance plan. Please complete the form attached and thank you for your cooperation.

Frequently Asked Question:

1. **When will my charge card be charged?** Your card will be charged either at time of service or once we receive notice from your insurance plan there is a balance owed by you for services. Generally, charges will appear around the 15th and 30th of the month.
2. **How much will be charged to my credit card**? There is no fixed dollar amount. The amount you owe Island Kids Pediatrics is deemed by your insurance plan and each insurance plan is different. We will only charge the amount deemed as **your patient responsibility**. In addition, your insurance plan is required by law to send you an Explanation of Benefits which indicates how your services were processed, paid and what is **your patient responsibility.**

3. **Will you send me a notification you made a charge on my credit card**? Yes, we will send you a notification. Please ensure you provided us with your email address and cell number.