Spring Valley Pediatrics PLLC

Account #_____

Credit Card Payment Authorization Form

I hereby authorize Spring Valley Pediatrics P.L.L.C. to charge the credit card indicated below after my visit for the full payment. This information will be kept in a secure location.

I understand that Spring Valley Pediatrics P.L.L.C. will charge my account within 72 hours of my child's visit.

I understand that this authorization will remain in effect until I notify Spring Valley Pediatrics P.L.L.C. otherwise.

I understand that if I need to change my credit card information, I can do so by calling the Billing office at 202-966-1157.

Patient(s) Name(s):_____

Name as it appears on card: _____

Billing Address: _____

City_____State_____Zip_____

Visa#: _____ Exp_____

MasterCard#: _____ Exp_____

Amex#: _____ Exp_____

Discover#: _____
Exp_____

Signature: _____ Date: _____