

# DUPAGE PEDIATRICS, LTD.

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## Credit Card on File Authorization

I acknowledge that I, the undersigned, am the authorized cardholder for the credit/debit/HSA card indicated below and my signature below authorizes DuPage Pediatrics, Ltd. to keep my credit/debit/HSA card on file. ***I understand that after claims are submitted and processed by my insurance company, my credit/debit/HSA card will be processed by DuPage Pediatrics, Ltd. for any unpaid balance that is more than 30 days beyond the date of the last statement generated.***

Cardholder's Signature \_\_\_\_\_ Date \_\_\_\_\_

Cardholder's Printed Name As It Appears On Card \_\_\_\_\_

Cardholder's Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Credit/Debit/HSA Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Please Circle Once:    Visa            Mastercard            Discover            American Express

### **Patients This Card Applies To (Please be sure to list all children that are patients of the practice):**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

11/4/2025

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**PLEASE RETURN FORM TO THE FRONT DESK**