## **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. I also authorize my credit/debit/HSA card to be credited by DuPage Pediatrics, Ltd. if I am due a refund.

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	<u></u>			
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	
Name			Date of Birth	
Name			Date of Birth	
Name			Date of Birth	
Name			Date of Birth	
Name			Date of Birth	

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