Integrative Pediatric Health Care, LLC
3540 S. Poplar St., Suite 202
Denver, CO 80237
(P) 720-442-3615 (F) 720-870-3726

Credit Card on File Authorization

Effective May 2021, Integrative Pediatric Health Care requires that **ALL** clients keep a credit/ debit card on file for all children that are seen in our clinic. (If you have active Medicaid coverage you will not be charged, but a card on file is still required.) This will assist in providing a contact-less check-in experience, and ensure that account balances/ statuses are as up to date as possible.

I agree to allow the practice to charge my credit card for the balance due, as determined by the final adjudication of this and all other claims included under this contract. I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below.

I certify and understand that I, the undersigned, am the authorized cardholder for the credit card indicated below. My signature below authorizes Integrative Pediatric Health Care to keep my credit/debit card on file. Card on File Agreements must be updated 365 days from the signed date. I understand that my credit or debit card will be processed for:

- The full amount due on a current statement (if my account with Integrative Pediatric Health Care has not been paid within 30 days of 1st statement, which is mailed on the 15th of the month)
- Full visit costs associated with self-pay patients
  - If you/ your family are self-pay patients it is **your** responsibility to request a Super Bill, if needed, following all visits.
- Any copayments due at the time of a visit(s).

I agree to these charges under the following conditions:

- The maximum charge amount in 365 days: $3,000.00
- The charges will take place upon receipt, or within a few days, of the final explanation of benefits from my insurance company.
- The amount charged to my card will not exceed the agreed- upon maximum dollar amount.
- I will receive a bill from the practice for any balance greater than maximum dollar for which I am liable.
- This contract is valid for one year starting from today.
- My credit card will be stored by a secure credit card processor affiliated with U.S. Bank that partners with the practice to collect payments.
- I will receive a receipt for any amount charged to my card once the transaction is complete.
- I may update my card information at any time by contacting the practice.

Card Information and Authorization

CC Number: _____

Exp. Date: _____ ***Security Code:*** _____ ***Billing Zip:*** _____

Cardholder's Name: _____

Cardholder's Signature: _____

Today's Date: _____

Agreement expires 365 days from today's date.

Patient(s) Name(s)

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