Primary Pediatric Medical Group, Inc.

FINANCIAL AND BILLING POLICY ACNOWLEDGEMENT
and
AUTHORIZATION FOR CREDIT CARD CHARGE
"EASY PAY" PLAN

Patient Name:___________________________________Date of Birth:_______________

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I have read and understand the PPMG financial policies dated February 2017 which may be subject to change, and I assign to the physician all payments for medical services rendered.

Patient/Parent/Guardian signature:_____________________________________

Patient/Parent/Guardian name printed:_________________________________

Date: ______________________

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I authorize Primary Pediatric Medical Group to bill my credit card for all patient balances due after claims are processed by my insurance carrier(s) if applicable. I understand that the credit card information will be safely transferred to a secure computerized billing software and the document with my CC information will be shredded. My authorized signature will be stored in my child's/children's electronic medical record. Updates to my card (expiration date or new card number) will be provided by me as needed.

Cardholder/Parent/Guardian Name: ____
(printed)

Cardholder Signature:____

Witness to Signature:_____________________________________Date:_____________