



Repetitive Payment Authorization

950 E Bogard Rd, Ste 233
 Wasilla, AK 99654
 907-357-4543 (office)
 907-357-4533 (fax)

I understand I have a balance due on my account. Instead of mailing a check or making a phone call to pay with a credit card each month, I would like Ptarmigan Pediatrics to automatically deduct the payment defined below on the schedule defined below until my balance is paid in full. A credit card receipt will be mailed to me after each payment has been drawn. I understand that I will continue to receive monthly statements on outstanding accounts while this balance is being paid off. If future charges result in a new, larger balance than the starting balance listed on this authorization, a new authorization will need to be signed.

Patient Name (first, middle, last). If paying for multiple children's accounts, list them all here:

Responsible Party (Name on the credit card)		
Name (first, middle, last)		Social Security Number
Home Phone ()	Work Phone ()	Cell Phone ()

FINANCING INFORMATION: Monthly payments will be paid directly from this credit card (Visa / MC) account.			
Starting Balance * \$	Monthly Payment \$	Debit my account on (or the next business day after) the [] 3rd [] 10th [] 18th [] 25th	* Combined balance due for all applicable children

Credit / Debit Card Information (Visa or Mastercard logo ONLY must be present)	
Card Number (16 numbers)	Expiration Date

"I hereby agree to authorize Ptarmigan Pediatrics to debit my visa / mastercard account for the terms and conditions noted above until the Starting Balance is paid in full. I am authorized to make this request."	
Signature of responsible party	Date

This form may be faxed, mailed, or dropped off at our office in person, as you feel comfortable.