South Tampa Kids Pediatric Care
Credit Card Authorization Form

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3314 Henderson Blvd Suite 100B
Tampa | Florida | 33609
P: 813-801-KIDS (5437) F: 813-822-0296

CREDIT CARD AUTHORIZATION

Cardholder Name (as it appears on card):	
Card Number:	
Expiration Date:	CCV2:

PATIENT INFORMATION

Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____

This authorization | consent will not expire unless the card on file has expired.

SIGNATURE

I hereby authorize South Tampa Kids Pediatric Care to charge the credit card listed above for payment of any outstanding charges at the point of care, within 48 hours of each visit date. This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by emailing a written request with 30 days notice to info.stkcare@gmail.com. A new application must be submitted if the users credit card is expired, lost, or stolen. Please notify us immediately. I understand my card information will be kept in a secure encrypted format. I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact South Tampa Kids Pediatric Care for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with South Tampa Kids Pediatric Care and those attempts have failed.

Print Name:	
X	
Signature of Parent | Guardian | Responsible Party	Date Signed

