Pediatric Feeding Institute
South Florida

NEW CREDIT CARD ON FILE AGREEMENT

We have implemented a new policy which requires all Pediatric Feeding Institute of South Florida, Inc patients to keep a credit card on file for payment purposes. We have a system which enables us to maintain your Credit Card information securely on file and which can only be accessed under the terms you specify below. By providing us with your credit card information, you are giving Pediatric Feeding Institute of South Florida, Inc. permission to automatically charge your credit card for the amounts due for therapy services received as follows: ***Please Initial that you have read the following statements:***

_____ Your credit card will be charged on a daily basis for the outpatient program if payment is not made by you on the day of your services.

_____Your credit card will be charged at the start of each week, on a weekly basis, for the intensive feeding day program if payment is not made by you at the beginning of each week of the program.

_____Your card will also automatically be charged if your account balance reaches $500 or more.

These payments will match the patient's responsibility amounts as determined by your insurance company and are reflected on the explanation of benefits (EOB's) from the insurance company.

_____Any canceled or missed appointments without a 24-hour notice will result in the credit card on file being charged accordingly (See cancelation policy)

If the credit card information we have on file changes for any reason, please notify Pediatric Feeding Institute of South Florida, Inc. as soon as you can. If you have any questions about a charge, please notify us. ***After 15 days, all charges will be assumed to be correct.*** We will maintain clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited and applied to your upcoming sessions. A receipt will be emailed to you. You may also ask to receive a paid invoice from Pediatric Feeding Institute of South Florida, Inc., showing your payment.

In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing treatments.

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE PEDIATRIC FEEDING INSTITUTE OF SOUTH FLORIDA, INC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

(circle one) VISA MASTERCARD AMEX DISCOVER CARD #: _____

EXP DATE: _____/_____ SECURITY CODE/CID #: _____BILLING ZIP CODE: _____

NAME AS APPEARS ON CARD: _____ Child's Name: _____

BILLING ADDRESS ON CARD: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS TO SEND RECEIPTS TO: _____

Parent's Signature: _____Date_____

www.pediatricfeedinginstitutefl@gmail.com
(add address, phone, fax)

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