Thrive
pediatrics

2410 Alft Ln Elgin, IL 60124 847-531- 4883

Credit Card on File Agreement

Effective Date:

Patient/Guardian Name: **Patient Date of Birth:**

Credit Card Information: **Cardholder Name:**
Credit Card Number:
Expiration Date: **CVV:**

1. Purpose
This agreement allows Thrive Pediatrics to securely store your credit card information for payment of medical services, including copayments, deductibles, and any outstanding balances. We will call you when balance is due prior to charging your credit card.

2. Authorization
You authorize Thrive Pediatrics to charge your credit card for:

- Outstanding balances after insurance.
- Non-covered services.
- Applicable copayments and deductibles.
- Products purchases

3. Security
Your credit card information will be stored securely with our payment processor, who adheres to the highest standards of security and data protection. We do not store your credit card details on our own systems, ensuring that your information is kept safe and confidential."

4. Updates
Notify us of any changes to your credit card information promptly to ensure accurate billing.

5. Consent
If you are receiving this document, you are acknowledging and agreeing to the terms of this agreement and authorize the use of your credit card as described.

Patient/Guardian Signature: _____
Date: _____

Patient Name: _____