PONDEROSA PEDIATRICS

6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
Fax: 775-900-9954

Credit Card Authorization

I authorize Ponderosa Pediatrics to charge my unpaid co-payment, work-in charges, HSA account and/or 60-day balances due under $500.00 to the credit card listed below. Any balance over $500.00 we are required to contact you to discuss payment terms.

This authorization will remain in force on each of my children's accounts up to 6 months, in the event they are no longer patients of Ponderosa Pediatrics, or until a written request by the cardholder is given by me, instructing the practice to remove the authorization.

Please give your card to the Front Desk to be scanned into our secure system.

Please circle: VISA MASTERCARD DISCOVER

_____ _____
Name on the Card Last 4 digits of card number

_____ _____
Cardholder Signature Date of Authorization

_____
Cardholder Email Address for all payment receipts

_____ _____ _____/_____/_____
Patient's Last Name Patient's First Name Date of Birth

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