



Credit/Debit Card Authorization Form

I authorize Dailey Pediatrics and Family Medicine, P.C. to keep the card listed below in my chart and charge the card listed below for services rendered for appointments via telehealth if telehealth services are rendered.

This card may also be utilized for payment plans and I agree for this card to be charged every two weeks from the date of visit, if I have set up a payment plan with Dailey Pediatrics and family Medicine, P.C.

Cardholder Name

Billing Address with zip code

Card Number

Expiration Date

CSV

Phone Number

Type of card (MC, Visa, Discover, etc)