NORTHAMPTON AREA PEDIATRICS, LLP

193 Locust Street
Northampton, MA 01060

170 University Drive
Suite 101
Amherst, MA 01002

269 Locust Street
Green Area – 3rd Floor
Northampton, MA 01060

29 Elm Street
South Deerfield, MA 01373

413-584-8700
413-584-1714 (fax)
Contactus@napeds.com
Pediatric and Adolescent Medicine

Credit Card Authorization Form

Patient / Family Information (List up to 5 children)

(If you have more than 5 children to enroll for authorization, please complete a second form.)

1. **Child #1 Name:** _____ **DOB:** ____ / ____ / ____
2. **Child #2 Name:** _____ **DOB:** ____ / ____ / ____
3. **Child #3 Name:** _____ **DOB:** ____ / ____ / ____
4. **Child #4 Name:** _____ **DOB:** ____ / ____ / ____
5. **Child #5 Name:** _____ **DOB:** ____ / ____ / ____

Responsible Party / Patient (18+) Name: _____
Relationship to children (if applicable): _____
Primary Phone: _____ **Email (for notifications):** _____

Important instructions — PLEASE READ

- **Do not write your full 16-digit card number on this paper/online form.** For your security, only enter the **last 4 digits** of the card below.
- **Provide the full card number and expiration date by phone** to our billing staff at 413-584-8700 option 8. This helps reduce the risk of paper/email exposure.
- We **do not** store CVV/security codes (per PCI rules). Do **not** record the CVV on this form.
- Once full card information is entered into our **encrypted, PCI- and HIPAA-compliant payment processor**, any full card data collected for entry will be **securely destroyed** (paper shredded and/or electronic temp data wiped) in accordance with our data-handling procedures.

Card on File Authorization — Terms

I authorize Northampton Area Pediatrics ("the Practice") to keep the card listed below securely on file and to charge it for patient-responsible balances for the child(ren) listed above, including:

- ☐ Copayments (at the time of service)
- ☐ Deductibles and Coinsurance (after the insurance has processed the claim)
- ☐ Non-covered services (after the insurance has processed the claim)
- ☐ Patient-responsible balances after insurance processing

Notification & Receipts

- The Practice will provide **at least 48 hours' notice** by email or text prior to charging this card for any amount **over $100**.
- Charges **$100 or less** (e.g., routine copays, coinsurance and/or deductible) may be processed without prior notice.
- You will receive an **itemized receipt** for each charge.

Collections

- This authorization is for **future charges only**. The Practice will **not** use this card to pay existing balances that have already been sent to collections without your **separate written consent**.

Revocation

- You may revoke this authorization at any time by providing written notice. If this authorization is revoked and an outstanding balance or collection account exists, payment may be required at the time services are rendered.

Card Details – * Please call our office (413-584-8700 option 8) to provide full card details PRIOR to sending this authorization form back to NAP

Cardholder Name (as printed on card): _____
Card Type: ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover ☐ Debit ☐ HSA/FSA ☐ Other: _____
Last 4 digits (to be written on form): ____ ____ ____ ____
Expiration (MM/YY): *full expiration provided by phone ONLY*
Billing ZIP Code: _____

I confirm that I provided the full card number and expiration date to the Practice by phone on:
____ / ____ / ____; and I spoke to _____ (billing representative).

☐ Initials of Responsible Party: _____

Security & Disposal Statement (Practice pledge)

By signing below you acknowledge that you were instructed to provide full card details by phone for confidentiality. Northampton Area Pediatrics will enter card information directly into our PCI- and HIPAA-compliant payment processor and will **securely destroy** any temporary record of the full card number (paper or electronic) used to perform that entry. The Practice does **not** retain CVV/security codes.

Signature & Authorization

By signing, I acknowledge I have read and understand this Credit Card Authorization Form and the Practice's Credit Card on File & Payment Policy. I agree to the terms above and authorize the Practice to charge the card on file for the patient-responsible charges described.

Signature: _____
Printed Name (responsible party or patient 18+): _____
Relationship to patient(s): ☐ Parent ☐ Legal Guardian ☐ Self ☐ Other: _____
Date: ____ / ____ / ____

Office Use Only
Staff who received full card info by phone: _____ Date: / /
Staff who entered data into processor: _____ Date: / /
Method of destruction (paper shred / electronic wipe): _____

Return to:

Northampton Area Pediatrics, LLP
193 Locust Street
Northampton, MA 01060

Fax: 413-584-1714

Email: Contactus@napeds.com – attention Billing