**ALL Pediatrics Contactless Payment Service**

**ALL Peds Contactless Payment Service** makes the check in process faster and your payments easier. It also allows us to implement a safe and contactless method for collecting payments.

1. I authorize **ALL Pediatrics** and/or its designated agent to apply co-payments, balances/outstanding balances, and fees to my payment card for all amounts owed.
2. I authorize **ALL Pediatrics** and/or its designated agent to send electronic account statements and receipts to my email address on file.
3. The card information is stored electronically in an encrypted form and cannot be viewed by **ALL Pediatrics** and/or its payment processor. Your signature below will authorize the card to be used ***14 days after your balance becomes due.***

*This policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our billing office.*

I agree to notify the practice of any changes in my payment information or email address.

AUTHORIZED SIGNATURE \_ DATE