GoldStar Pediatrics
Dr. Ritu Khullar MD, FAAP

Easy Pay Consent Form

I authorize Goldstar Pediatrics to charge my credit or debit card listed below for the following:

- Copays or co-insurance
- Deductibles
- Balance of charges unpaid
- Services not covered under my insurance plan

We will charge your credit card in the following cases only:

a. You directly authorize us, or
b. We have sent you 2 statements and the balance is not paid, or
c. Your balance is 90 days past due

I understand the form is valid until the expiration date of the listed card unless I cancel the authorization by written request.

Receipt will be provided with the statement of charges.

Patient Name (s): _____

Card Holder Name: _____

Card Holder Address: _____

City: _____ State: _____ Zip: _____

Select one: Visa ___ MC ___ Amex ____ Discover ___ Debit _____

Account #: _____

Verification # _____ Exp Date: _____