Salud Pediatrics

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Algonquin, IL 60102
Tel: 847.854.9402
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CREDIT CARD AUTHORIZATION

I authorize Salud Pediatrics S.C. to maintain my credit/debit card on file. I understand the card will be used if my child's account has been **delinquent** for more than **90 days** and I have not made any effort to make payment arrangements.

______________________________ ______________________

Cardholder Signature Date

Patient's Name:		Account No.	
Cardholder's Name:		Phone	
Cardholder's Address:			
City:	State:	Zip:	
_____ VISA ___ MC			
Credit Card Number:		Exp:	CVV: