Children's Medical Group
100 Highland Avenue
Providence, RI 02906

Lighthouse MD
Pre-Authorized Healthcare Payment Form

I authorize Lighthouse MD, the billing company for Children's **Medical Group**, to keep my signature on file and to charge my credit card as indicated below:

Personal Credit Card:____

All medical visits, procedures or supplies for calendar year 2010, to include the balance of charges not paid by insurance within 90 days and not to exceed $________________

I assign my insurance benefits to the provider listed above. I understand this form is valid for this calendar year unless I cancel the authorization through written notice to Children's Medical Group. I further understand that I can cancel the authorization only for future services.

Authorization for services already rendered cannot be cancelled or refunded.

Charges on your monthly statement will be listed as "LighthouseMD", our medical billing company.

Patient Name:____

Cardholder Name:____

Cardholder Address:____

City State Zip:____

Last 4 digits of Credit card number only:________________________________

Expiration Date:____

Cardholder Signature/Date____