AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Upon approval, you will have the option to make monthly payments or set up a monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic statement sent to your email.

Your statement will include monthly fees and incidental charges, which you will receive prior to any payments or deductions.

Patient(s) Name(s): ____

PAYMENT INFORMATION

I authorize ACCESS FAMILY MEDICINE to automatically bill the card listed below as specified:

Amount: $__________ ☐ **Incidental Charges** **Frequency:** Monthly

Start Date: ___/___/___ **End Date:** Upon card member cancellation.

CREDIT/DEBIT CARD INFORMATION (Visa, MasterCard, American Express, Discover)

Credit Card Type: _______________ Credit Card Number: ______________________________ Expires: ____/____

Cardholder's Name (as it appears on the card): ____

CVC (Security code) ____________

Customer's Signature: ____

Date: ____________