**Recurring Payment Authorization Form**

Schedule your payment to be automatically deducted from your bank account or charged to your visa, MasterCard, American Express, or Discover card. Just completed and signed this form to get started!

**Here is How Recurring Payments Work:**
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an “ACH debit.” You agree that no prior- notification will be provided unless the date or amount changes, in which case you will receive notification from us at least 10 days prior to the payment being collected.

**Please complete the information below:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorized Superstition Family Medicine, LLC, to charge my credit card or bank account for $50 on the 25th of each month for payment of my primary care services.

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing via text message or email. I agree to notify Superstition Family Medicine of any changes to my account information or termination of this authorization within 48 hours prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debit to my checking savings account, I understand that because there are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction date. I certify that I am the authorized user of the provided credit card or bank account and will not dispute these scheduled transactions with my bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form. I understand that I am obligated to prevent insufficient funds transactions to my account provided to Superstition Family Medicine, LLC and that I am subject to an $25 charge if funds are not available on payment date stated above.