

HARRIS HEALTH AND WELLNESS AUTOMATIC BILLING AUTHORIZATION

For the convenience of automatic, reoccurring billing, simply complete the checking or debit/credit card information sections below and sign the form. Upon approval, we will automatically bill your checking account or debit/credit card for monthly fees and related incidental charges, pursuant to the Patient Agreement for signing your child. You will receive a statement prior to any payment deductions.

Patient(s) Name(s): _ _

Credit Card Information:

Card Type: __MasterCard __Visa __Discover __Amex

Cardholder Name: _____ Billing Zip Code: _____

Card #: _____ Security Code: _____ Expiration: ____/____

Banking Information:

Name of Account: _____

Authorized Individual: _____

Account Number: _____ Routing Number: _____

AUTHORIZATION

I authorize, Harris Health And Wellness, LLC, to automatically bill the bank/checking account or credit/debit card listed above, as specified.

Product/Service Description: Medical Services

Recurring Amount: _____

☐ **Incidental (varying)Charges**

Frequency: Monthly

Account Holder's Signature _____ Date _____