Wholesome FAMILY MEDICINE

Naturopathic Primary Care for the Whole Family

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Credit Card on File for Membership Fee Agreement

Primary Patient Name: _____ DOB:_____

Included Family Members: _____

_____ I authorize the office of Wholesome Family Medicine to debit the card listed below for the amount of _____ each month, on or about the 5th of the month, for my/my family membership fee. I understand that should my card decline that I will receive an email acknowledging a failed subscription charge and that it is my responsibility to remedy this situation immediately. Should I fail to remedy this issue by the 10th of the month I understand my membership may be cancelled and all upcoming scheduled appointments canceled or changed per membership agreement.

_____ I understand that this membership fee is not covered by my health insurance. I have signed a Member Rights and Responsibilities form and understand the included and excluded benefits covered by this membership.

_____ I understand that this form remains valid unless I give a 30 day written notice to the office contact information listed above or in person. I certify that I am an authorized user of this credit/debit card and that I will not dispute the use of this card with my bank/credit card company for payment as indicated on this form.

_____ I understand that my credit card information will be kept in the highest of confidentiality and will be stored securely electronically in Quickbooks and on this form which will be maintained in a secured and locked location on site at the office contact above.

Cardholder's Name (as shown on card): _____

Card Number: _____ Expiration date: _____

CVV: _____ Billing Zip Code: _____

Email address: _____

Cardholder Signature:_____ Date: _____