**Automatic Billing Authorization**

To enjoy the convenience of automated billing, simply complete and sign this Automatic Billing Authorization form. All requested information is required.

Your statement will include monthly fees and incidental charges, which you will receive prior to any payments or deductions, for the following Members:

Patient(s) Name(s): \_ \_

**PAYMENT INFORMATION**

**CHECK ONE:**

**\_\_\_\_Bank Draft**

Name(s) on Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Name of Bank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Routing Number:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_Credit/Debit Card**

Card Type: \_\_\_ MasterCard \_\_\_ Visa \_\_\_ Discover \_\_\_ Amex

Cardholder Name (as shown on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_ Expires: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Billing Zip Code:

**Authorization**

I authorize Charmed Direct Primary Care to automatically bill the account listed above as follows:

**Amount:** $ 🞏 **Incidental Charges Frequency:** Monthly

**Start Date:**  / /  **End Date:** Upon cancellation.

Account Holder’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_