Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
P.O. Box 2559
Smithfield, NC 27577
Phone (919) 901-7344 Fax (319) 250-7453

Autopayment Agreement

Please complete the information below:

Patient: _____ DOB: _____

Address: _____

City/State/Zip: _____ Phone: _____

I, _____, authorize Hometown Direct Primary Care PLLC to charge my debit/charge card or withdraw from my selected banking account the amount agreed upon in the membership agreement on the first business day of each month.

□ Debit/Credit Card Billing

Type of Card: □ Mastercard □ Visa □ Other _____

Card Number: _____ Exp Date _____

□ Bank Account Direct Debit

Type of Account: □ Checking □ Savings

Routing #: _____ Acct #: _____

I understand that this authorization will remain in effect until I cancel it in writing. I also agree to notify Hometown Direct Primary Care PLLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If an ACH transaction is rejected for non-sufficient funds, I will be charged an additional $30.00 for each such transaction. I understand that Hometown Direct Primary Care PLLC may at its discretion attempt to process the charge again within 30 days. I certify that I am an authorized user of this credit card/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 my membership agreement.

Signature: _____ Date: _____