**Automatic Payment Authorization Form**

This form authorizes Southeast Medical Clinic to charge your credit or debit card for payment on your account on a monthly basis.

* Your credit/debit card will be charged on the 25th of each month

(or the next business day if the 25th is not a business day).

* You will still receive a monthly statement if your account has a balance.
* If the charges are denied by your credit/debit card company,

you will receive notification on your monthly statement.

* This agreement can be terminated at any time by either party by written notice.

I hereby authorize Southeast Medical Clinic to charge $\_\_\_\_\_\_\_\_\_\_\_\_\_ to the following credit/debit card on a recurring monthly basis for payment to the account of:

(Patient’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit or Debit Card Information:**

 [ ] VISA [ ] Master Card [ ] Discover

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

Expiration Date: \_\_\_\_\_/\_\_\_\_\_ CVV code: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Card Billing Address:**

Street / PO Box: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the credit/debit card holder, I agree to pay and be charged automatically for the amount entered above. If I wish to make changes to this agreement I will notify Southeast Medical Clinic prior to the 25th of the month.

Cardholder’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mail the completed form to Southeast Medical Clinic at the above address.**

Southeast Medical Clinic will keep all information entered on this form strictly confidential.