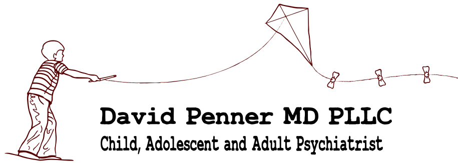

IF YOU WISH TO KEEP A CREDIT CARD ON FILE FOR AUTOMATIC PAYMENT OF COPAYS

Patient Name:____ Date of Birth ___________________
First Middle Last

Billing Information:

Accountholder Name:____

Account Billing Address ____

____

City____ State________ Zip ____________________

Account Phone ____

Card # ____

Exp: _______________/ _________ Security Code on Back of Card (3 or 4 digit) _______________

Email if you would like receipts: ____

Card on File Agreement **Payment on file / automatically deleted on expiration of card.**
Not to exceed: $375.00 for any single charge

I hereby authorize David Penner MD PLLC to keep my account information on file for payment and to initiate debit or charge entries on this account as amount are owed for the Patient Account listed above. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify David Penner MD PLLC. This authorization shall remain in effect until **the end date as listed above** or until David Penner MD PLLC has received written notification from me of its termination..

X__________________________ Date: ___________

cardholder

p: 360 539 1736 **f:** 360 350 5610
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