Credit Card Pre-Authorization Form

I authorize _____ to keep my signature on file and to
(Name of Provider's Office)

charge the credit card selected below for the following:

☐ **Balance remaining after claim (s) is (are) resolved not to exceed $_____ for:**

- ☐ This consultation only
- ☐ All consultations this calendar year
- ☐ All consultations from _____ (date) to _____ (date)

☐ **Recurring charges of $_____ to be charged every _____** (frequency)

- ☐ From _____ (date) to _____ (date)

☐ **Charges for the following family members:**

_____ (authorized family member) _____ (authorized family member)

_____ (authorized family member) _____ (authorized family member)

Check One:

☐ Visa®
☐ MasterCard®
☐ Discover Card®

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ **Date:** _____

VISA MasterCard DISCOVER

ACH Pre-Authorization Form

I, we, authorize _____ to keep my signature on file and to initiate debit entries to my (our):

☐ Checking Account ☐ Savings Account (*select one)*

indicated below, at the depository financial institution named below, herein called DEPOSITORY, and to debit the following to such account:

☐ **Balance remaining after claim (s) is (are) resolved not to exceed $_____ for:**

☐ This consultation only
☐ All consultations this calendar year
☐ All consultations from _____ (date) to _____ (date)

☐ **Recurring charges of $_____ to be charged every _____** (frequency)

From _____ (date) to _____ (date)

☐ **Charges for the following family members:**

_____ (authorized family member) _____ (authorized family member)

_____ (authorized family member) _____ (authorized family member)

Depository Name_____ Branch_____

City_____ State_____ Zip_____

Routing Number_____ Account Number_____

I (we) also acknowledge that our paper check may be turned into an electronic funds withdrawal from our account and understand we will not receive our check back from our financial institution

I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Name(s)_____
(Please print)

Date: _____ **Signature**_____

This authorization is valid until I (we) provide you with written cancellation.

WINFIELD FAMILY MEDICINE

PAYMENT ARRANGEMENT CONTRACT

DATE: _____ ACCOUNT #: _____

GUARANTOR'S NAME: _____

COMPLETE ADDRESS AND HOME, CELL AND WORK PHONE NUMBER:

_____

_____

CURRENT ACCOUNT BALANCE: $_____
PAST DUE ACCOUNT BALANCE: $ _____

I AGREE TO MAKE A REGULAR MONTHLY PAYMENT IN THE AMOUNT OF $_____ A MONTH. BALANCE MUST BE PAID WITHIN THREE (3), SIX (6) MONTHS OF THE AGREEMENT. IN THE EVENT I AM UNABLE TO MAKE THIS PAYMENT I WILL CONTACT THE BILLING DEPARTMENT IMMEDIATELY TO MAKE ALTERNATIVE ARRANGEMENTS. FAILURE TO MAKE THE AGREED MONTHLY ARANGMENT WILL RESULT IN YOUR ACCOUNT BEING ENTERED INTO COLLECTION PROCESSING AND/OR SENT TO A COLLECTION AGENCY. ADDITIONAL FEE WILL INCUR. FAILURE TO ABIDE BY THE PAYMENT ARRANGEMENT WILL BE GROUNDS FROM DISMISSAL FROM THE PRACTICE.

SPECIAL PAYMENT
ARRANGMENTS:_____

_____

_____

_____

If you have any questions, regarding this payment arrangement, please call the office at 219-226-1529 between the hours of 9-3 Tuesday through Friday.

I HAVE READ AND UNDERSTAND THIS FINANCIAL CONTRACT AGREEMENT.

SIGNATURE: _____DATE: _____