Faith Immediate Care & Occupational Medicine

Authorization for Automatic Payment

(Credit Card, Debit Card or Bank Account Authorization)

Primary Account Information
ATTACH VOIDED CHECK FOR BANK ACCOUNTS

Enrolling Member Name: _____

Name as it appears on Credit/Debit Card or Bank Account: _____

Card No / Account Number: _____ Account Type: _____

Card Expiration Date: _____ Security Code (on reverse): _____

Billing Address for Credit/Debit Card: _____

Secondary Account Information
ATTACH VOIDED CHECK FOR BANK ACCOUNTS

Name as it appears on Credit/Debit Card or Bank Account: _____

Card No / Account Number: _____ Account Type: _____

Card Expiration Date: _____ Security Code (on reverse): _____

Billing Address for Credit/Debit Card: _____

Monthly Amount: $_____

I hereby authorize Faith Immediate Care & Occupational Medicine (Faith) to charge the above referenced credit/debit card or bank account automatically every month, and apply those charges to the membership fees required for participation in the direct primary care membership offered through Faith, and to any other charges I incur from services received through the participating clinics or providers that are not covered by membership. I understand that I will remain responsible for recurring charges, additional late fees and any other applicable charges if the withdrawal to the bank account I have listed above is denied for insufficient funds or the account otherwise becomes unavailable.

In the event I have selected to have automatic payments made from a bank account, I hereby authorize Faith to initiate automatic withdrawals via electronic fund transfer entries by Faith in existence as of the date of this agreement and as amended from time to time. I acknowledge that no entries may be made that violate the laws of the State of Missouri, or the laws of the United States. I agree to indemnify the originating depository institution and any third party service providers involved in processing entries made hereunder against all claims, demands, losses, liability, or expense including attorney's fees and costs that result directly or indirectly from 1) a failure to follow the rules, 2) violation of law.

I understand it is my responsibility to notify Faith of changes to my address, phone number, email address and other billing or contact information. An inability to collect membership fees due to incorrect or outdated billing information will result in the termination of my Faith membership, including family members signed up under the membership, and a re-enrollment fee of $49 per member.

_____	_____	_____
Member's Printed Name	Signature	Date
_____	_____	_____
Faith Immediate Care Representative Printed Name	Signature	Date