

Authorization Form for Automatic Payment Arrangements

This form is to confirm the arrangement under which WingHaven Pediatrics will accept payment for your child/children’s account.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A MINIMUM BALANCE OF $ 40.00 PER MONTH MUST BE PAID.**

Please fill out the following information for credit / debit card account transactions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of credit / debit card Name on card Account Number**

Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date payments to start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Three digit security code on back: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Amount to charge \_\_\_\_\_\_\_\_\_ How Often: weekly \_\_\_ bi-weekly \_\_\_ monthly \_\_\_**

**Please read and initial box’s below:**

 **If your scheduled payment is denied for insufficient funds or credit card denial, the remaining balance will be due in full, within thirty days of the denial date. If payment is not received in full we may seek further collection assistance.**

 **It is your responsibility to notify us with ANY changes to your account information. Please contact us at 636) 561-5561.**

By signing below I am authorizing WingHaven Pediatrics to automatically withdraw my monthly payment from my bank or credit / debit card account.

**I understand that this authorization will continue until all past, current and future balances are paid in-full.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_