

Credit Card Authorization

The following conditions apply to the recurring payments program:

1. If any payment is refused by a bank or credit card issuer you may no longer be eligible for recurring payments and may be discharged from Hirsch Holistic Family Medicine.
2. All future installment payments will be processed via recurring payments as required by the Hirsch Holistic Family Medicine Patient Handbook.
3. You may discontinue the recurring credit card plan anytime by providing Hirsch Holistic Family Medicine with 30 days written notice. Please be aware that Hirsch Holistic Family Medicine financial policy requires recurring Visa, MasterCard for all monthly and quarterly payments.

The undersigned authorizes Hirsch Holistic Family Medicine to debit my Visa or MasterCard for future payments AND for any outstanding balances due on my Hirsch Holistic Family Medicine *Insurance / Membership / Wellness Program (circle one)*.

Please charge my card \$ _____ per month/quarter/year (circle one) for program services noted above.

I agree to make all future payments under this recurring charge authorization according to my credit card statement. I understand that my Hirsch Holistic Family Medicine membership will be subject to cancellation if my credit card is declined or if I contest any recurring charge made under this recurring payments authorization. **ALL RECURRING CHARGES WILL SHOW ON YOUR CREDIT CARD STATEMENT AS HIRSCH HOLISTIC FAMILY MEDICINE.**

Patient Name

Card Holder's name
(as it appears on the card)

Credit Card Number

Visa Mastercard

3 Digit Number from Back of Card

Expiration Date

Credit Card Billing Address

Street Address

City State Zip

Signature

Date

Please email me my monthly receipt to: @