Payment Authorization Form

I _____ authorize Hometown Pediatric Dermatology PLLC to charge my credit card, debit card or bank account using the information indicated below for payment of services, missed appointments or any other payments legally owed by me at Hometown Pediatric Dermatology PLLC.

Billing Address_____ Phone#_____

City, State, Zip _____

Email_____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

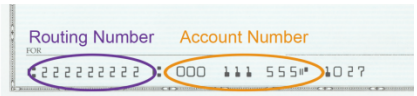
Bank Name _____

Account Number

_____

Bank Routing # _____

Bank City/State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Amex

Cardholder Name

_____

Account Number_____

Exp. Date _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Hometown Pediatric Dermatology PLLC in writing of any changes in my account information or termination of this authorization. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Hometown Pediatric Dermatology PLLC may at its discretion attempt to process the charge again. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. Law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.