Credit Card – Recurring Payment Form

Authorization Agreement for Baptist Health Automatic Payment Withdrawal
I (we) hereby authorize Baptist Health to initiate debit entries to my (our) Credit Card account indicated below and the depository named below and I (we) authorize the depository to debit the same to such account. This authority is to remain in full force and in effect until the patient's account at Baptist Health is paid in full or Baptist Health and the depository have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Baptist Health and depository a reasonable opportunity to act on it.

***Account Number**_____ ***Patient Name**_____

***Date Of Service**_____ *** Monthly Payment** ($50 minimum)**$**_____

***Mailing Address**_____

***City** _____ ***State**_____ ***Zip Code**_____

***Home Phone**_____ ***Email Address**_____

CREDIT CARD INFORMATION

***Name on Credit Card**_____

Visa ☐ **Matercard** ☐ **American Express** ☐ **Discover** ☐

***Credit Card Number**_____ ***Expiration Date**_____

***Security Code**_____ ***Day of Month to Process**_____
(this is the 3 digit code located on the back of your card.

By placing your name in the box you are stating that you are the patient or guarantor on this account and that all information provided is current and accurate to the best of your knowledge.

***Patient/Guarantor**	***Date**

*** Mandatory Information**