SUMMIT
HEALTH GROUP
Primary Care • Integrative Medicine • Physical Therapy • Chiropractic

Authorization to Bill Credit Card

Membership 2019/2020

Patient Name: _____ Patient Email:_____

I, _____ patient of Summit Health Group authorize to have my credit card charged on a monthly basis as per my Membership Agreement.

I authorize $_____ to be charged **in 4 Monthly Payments** until

my balance of _____ is paid off.

Start Date: _____ End Date: _____

PATIENT PLEASE READ AND INITIAL

_____ *Cardholder acknowledges receipt of goods and/or services in the amount of the total shown here on and agrees to perform the obligations set forth by the card member's agreement with the issuer.*

Credit Card #:_____Name on card:_____

CVV Code:_____Biling zip code:_____Exp. Date:_____

Credit Cars Type: VISA MASTERCARD AMEX DISCOVER

Staff Signature:_____Date:_____ Entered into Recurring on:_____