INITIAL POINT | FAMILY MEDICINE

AUTOMATIC BILLING AUTHORIZATION FORM

FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card(s) listed below:

Primary Card Account

Name on credit card (exactly as printed)

Billing Address for credit card (Street, Apt. #)

City, State Zip

Credit card number | Expiration Date

Signature | Today's Date

Secondary Card Account

Name on credit card (exactly as printed)

Billing Address for credit card (Street, Apt. #)

City, State Zip

Credit card number | Expiration Date

Signature | Today's Date

☐ This authorization is valid until I provide you with written cancellation.