My Country Doctor

Billing/Payment Authorization

Billing Frequency: monthly payment on first of month or first of year

Option A: Credit Care or Debit Card

Name on Card: _____

Card Type (circle): Visa Master Card Discover Card

Card Number: _____

Expiration: _____

Security Code: _____

Billing Address: _____

_____

Option B: Automatic Funds Transfer *(please attach a voided check to this form)*

Name on Account:_____

Bank Name: _____

Account Type(circle one): Checking Savings

Account Number: _____

Bank Routing Number: _____

Authorization:

Your monthly care fee covers the services described in the My Country Doctor Services Guide and is outlined in the Patient Agreement. At times, however, your care may require durable medical supplies, special services or third party services that are not covered by your monthly care fee. The fee for the My Country Doctor services are posted in the office, on the website and brochures. Please note that by providing the above billing information you authorize My Country Doctor to automatically charge your card or draw on your bank account for your monthly fees and any incidental items at the time of service. In all cases, incidental items are charged at or near our cost and will be discussed with you in advance.

By signing below, I hereby authorize My Country Doctor to contact me using the information I have provided above. By signing below, I hereby authorize My Country Doctor to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date.

I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.

1. This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until My Country Doctor has received written notification from me of its termination at such time and in such manner as to afford My Country Doctor and my financial institution a reasonable opportunity to act on it.
2. I understand that my participation in My Country Doctor is continuous and that, by signing below, I authorize recurring credit/debit charges.
3. I understand that a $25.00 fee will be charged to me for declined credit or debit card and/or Paypal transactions not honored.

Account Holder Signature: _____

Start Date:_____