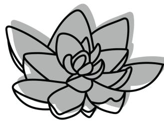

HOPE419

CREDIT CARD AUTHORIZATION

PATIENT NAME ______________________________

- ❏ I hereby authorize HOPE419 to initiate a one time credit card charge in the amount of $__________.

- ❏ I hereby authorize Hope419 to charge the indicated credit card for fees associated with my office visits (including copays, coinsurance amounts, and balances), including, if necessary, adjustments for any changes to my account. I agree that periodic office visit charges will be applied to my credit card at the time of service, and I will receive email receipts, if designated above. I also agree that I will not dispute any charges with my credit card company without first making a good faith effort to remedy the situation directly with Hope419. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this recurring credit card billing agreement with Hope419 I further understand that I am required to contact Hope419 in advance of future visits to cancel or change this billing authorization.

This amount will be applied to my account balance to offset charges for services and fees.

NAME AS SHOWN ON CARD: ______________________________

CARD TYPE: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

CARD NUMBER: ____

EXPIRATION DATE: _____________________________________

CVC (3 or 4 digit number on back of card): _________________

BILLING ZIP CODE: ____________________________________

Please email my receipt to: _______________________________

Please text my receipt to: ________________________________

SIGNATURE: ____

DATE: ____