haven
direct primary care

AUTOMATIC BILLING AUTHORIZATION

For the convenience of automatic, reoccurring billing, simply complete the checking or debit/credit card information sections below and sign the form. Upon approval, we will automatically bill your checking account or debit/credit card for monthly fees and related incidental charges, pursuant to Appendix C of your Patient Agreement. You will receive a detailed statement regarding any payment deductions.

Patient(s) Name(s): _____

_____

CHECK ONE:

___Checking Account Info:

Name on Account: _____

Bank Name: _____

Account #: _____ Routing #: _____

___Credit Card Info:

Card Type: ___MasterCard ___Visa ___Discover ___Amex

Cardholder Name: _____ Billing Zip Code: _____

Card #:_____ Security Code: _____ Expiration: _____/_____

AUTHORIZATION

I authorize Haven Direct Primary Care, LLC, to automatically bill the checking account or credit/debit card listed above, as specified.

Product/Service Description: Medical Services_____

Recurring Amount: _____ ☐ **Incidental (varying)Charges**

Frequency: Monthly

Account Holder's Signature_____ Date _____