Payment Authorization

emc2care™
ALPHARETTA MEDICAL ASSOCIATES

I, the undersigned authorized user/signer on the account from which funds will be drawn, authorize my bank or credit card institution to honor preauthorized Electronic Funds Transfers (EFT) or charge authorizations, as indicated below, drawn by emc2care for Membership Fees and any additional fees incurred pursuant to the emc2care Enrollment Form. When the bank or credit card institution honors the EFT or credit card by charging my account, this transfer will constitute notice of payment due and my receipt for the payment. The amount debited via EFT or credit card will be the total due on the 25th day of each month. Should any preauthorized EFT or credit card not be honored by said bank or credit card institution when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus any applicable late, return or other fee. It is further understood that if such payment is not honored by the bank or credit card institution, then emc2care, at its discretion, may resubmit the amount due for payment on a future date. This authority is to remain in full force and effect until emc2care has received written notification from me of its termination in such time and in such manner that emc2care has a reasonable opportunity to act on it.

PATIENT NAME

SOCIAL SECURITY NUMBER | HOME PHONE | WORK PHONE

PATIENT SIGNATURE | DATE SIGNED

ELECTRONIC FUNDS (EFT), CREDIT CARD OR MONTHLY STATEMENT INFORMATION

☐ I choose to utilize the EFT option for the monthly payment. Direct debit from my: ☐ Checking ☐ Savings account

BANK NAME | NAME ON ACCOUNT

ROUTING/TRANSIT NUMBER | ACCOUNT NUMBER

AUTHORIZED SIGNATURE | DATE

REQUIRED: Attach a voided check if using the checking account option and a deposit slip for the savings account option

☐ I choose to utilize the Credit Card option for the one time annual payment

☐ I choose to utilize the Credit Card option for the monthly payment (automatic direct charge to credit card)

☐ Please keep my credit/debit card information on file to pay for co-payments or account balances

Credit Card Type: ☐ Visa ☐ MC ☐ AMEX ☐ Discover

NAME ON CREDIT CARD

ACCOUNT NUMBER | EXP. DATE

AUTHORIZED SIGNATURE | CVV/CVC NUMBER | DATE

BILLING ADDRESS

AUTHORIZED SIGNATURE | DATE

FOR OFFICE USE ONLY

MEDICAL RECORD NUMBER

MEMBERSHIP TYPE
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

PAYMENT METHOD
☐ Checking Account Draft
☐ Saving Account Draft
☐ Credit Card
☐ Monthly Statement

MONTHLY FEES
$ _____
$ _____
$ _____
$ _____

EFFECTIVE DATE | EXPIRATION DATE

KEYED BY | DATE KEYED