Pre-Authorized Payment Form

(confidential when complete)

Your name: ____

University Women's HealthCare Account #:_____________ Main Telephone #: _________

1. PLEASE CHECK ONE:

- ☐ New Enrollment in Pre-Authorization Payment Plan
- ☐ Make changes to an existing Pre-authorized Payment Plan

2. PLEASE INDICATE YOUR PAYMENT METHOD:

- ☐ Credit Card (Please provide Credit Card Information)
  - ☐ Visa
  - ☐ MasterCard Credit Card #: Expiration Date:
- ☐ Commercial Insurance Card (please indicate carrier) ____________________________

3. WITHDRAWAL INFORMATION:

Preferred Payment Date: (optional) _______________ (1-30) day of every month

Payment Amount: $___________________________

I hereby authorize University Women's HealthCare, PSC and the credit card issuer indicated to release funds for payments for billed charges under the terms and conditions of this request. All terms are subject to cardholder's agreement with my financial institution.

Signature:______________________________ Date: ______________________

Daytime contact number: ____________________________________

TERMS AND CONDITIONS

1.) I understand that this authorization to University Women's HealthCare is exactly the same as if I authorized the credit card institution or the branch of my bank/financial institution where I keep the bank account. The credit card institution or bank branch will treat every withdrawal or debit as though I had personally directed them to make payments, an will charge the specified amount to my account.

2.) I will let University Women's HealthCare know, in writing, of any changes in the credit card or account information or my pre-authorized payment does not cancel my service with University Women's HealthCare, nor does it end my obligation to pay University Women's HealthCare in the normal fashion.