WEST BEND FAMILY MEDICINE

Authorization for Automatic Payment

(Credit Card, Debit Card, or Bank Account Authorization)

Enrolling Member Name: ____

Name as it appears on credit/debit card or bank account: ________________________________

Account Type (credit card or bank account):____________________Routing number: ________________

Account Number (credit card or bank account): ____

Card Expiration Date:______________________________Security Code (on reverse): ________________

Billing Address for Credit/Debit card: ____

Initiation fee to be charged: ____

Monthly membership amount to be charged or withdrawn each month: ___________________________

Date of recurring monthly membership charge (1st or 15th of the month) __________________________

I hereby authorize WEST BEND FAMILY MEDICINE to charge the above referenced credit card or bank account automatically every month and apply those charges to the membership fees required for participation in the direct primary care membership offered through West Bend Family Medicine, and to any other charges I incur from services received that are not covered by the membership. I understand that I will remain responsible for recurring charges, additional late fees, and any other applicable charges if the withdrawal to the bank account I have listed above is denied for insufficient funds or the account otherwise becomes unavailable.

In the event I have selected to have automatic payments made from a bank account, I hereby authorize West Bend Family Medicine to initiate automatic withdrawals via electronic fund transfer as of the date of this agreement and as amended from time to time. I agree to indemnify the originating depository institution and any third-party service providers involved in processing entries made hereunder against all claims, demands, losses, liability, or expense including attorney's fees and costs that result directly or indirectly from 1) a failure to follow the rules, 2) violation of law.

I understand it is my responsibility to notify West Bend Family Medicine of changes to my address, phone number, email address and other billing or contact information. An inability to collect membership fees due to incorrect or outdated billing information will result in the termination of my West Bend Family Medicine membership, including family members signed up under the membership.

Authorized Signature:____ Date: _______________