830 EYRIE DR. SUITE 6B
OVIEDO, FL 32765
PH# 800.330.2313
Fax # 407.365.0774 or
866.413.5202

Payment Authorization Form

Check One→ Payment Arrangements_____ One Time Only Payment _____

Patient Name: _____
CMSI Account #:_____ Phone # _____
Address: _____ City_____ State/zip_____

Name and Address of the Credit Card Account Holder (Billing address of credit card)

_____

_____

Credit Card (circle one) : Visa / Mastercard
Institution Name :_____
Credit Card Account Number_____
Exp. Date: _____ 3 Digit Security Code on Back of Card_____
I hereby authorize *CMSI* to charge my Credit Card listed above in the amount of :

( )$10 ( )$20 ( )$50 ( )other_____ *(greater then $75)* on this date each month_____ OR on this date _____ (one time payment)

I agree that each charge to my account shall be the same as if I had signed a check to pay my account. I understand that it is my responsibility to notify ***CMSI*** in writing if I change my credit card information, address and phone number. This authorization will remain in effect until either party gives written notice to the other of termination. I understand my notice of termination must be received in time to have reasonable opportunity to act. If my credit card is declined for whatever reason, I understand that ***CMSI*** will attempt to contact me for alternate payment arrangements. I understand if charges are denied 3 times within 12 months a penalty fee of $35.00 will be applied to my balance.

By signing this authorization, I acknowledge that I have read and agree to all of the above.

Print name:_____

Signature:_____ Date: _____