



RECURRING PAYMENT AUTHORIZATION FORM

Date:		Member Name:			
Physical Address:		City:	State:	Zip:	
Mailing Address: <input type="checkbox"/> Same		City:	State:	Zip:	
Main Phone #: ()		Alt. Phone#: ()		Fax #: ()	
Email address:					
CREDIT CARD PAYMENT INFO					
Card Number:					
Exp Date:					
CVS Code:					
Name On Card:					
AMOUNT DUE UPON ENROLLMENT					
<p style="color: red; font-size: small;">Automatic monthly payment by credit card or debit card is required to enroll in Direct Primary Care Membership. By filling out and signing this form you are giving authorization for Faith Immediate Care to charge your account for the amount indicated on this form on the date indicated on this form. You may cancel this automatic payment authorization at any time by contacting us.</p>			Enrollment Fee: \$25.00		
			Monthly Fee: <u>\$39.00</u>		
			Total \$64.00		
			Date Charged: _____		
How did you hear about us?: (Please check one)			<div style="text-align: center; margin-bottom: 10px;"> </div> <div style="display: flex; justify-content: space-around; font-weight: bold;"> Signature Date </div> <p><input type="checkbox"/> Notify me via email when my credit card/debit card is charged. (make sure email address above is correct.)</p>		
<input type="checkbox"/> Commercial <input type="checkbox"/> Website Referral*					
<input type="checkbox"/> Mail Out <input type="checkbox"/> Current Client*					
<input type="checkbox"/> Insurance Agent* <input type="checkbox"/> Search Engine*					
<input type="checkbox"/> Other					
<p style="font-size: x-small;">* Please List Name of Referrer</p> <p>_____</p>					