MONTHLY RECURRING CREDIT CARD AUTHORIZATION FORM

Yes, I want to pay my Carolinas Dermatology Group, P.A. balance through automatic monthly billing to the designated credit card.

1. **Please fill out the following information:**

Name: _____ Date of Birth: _____

Account #: _____ Telephone #: _____

Mailing Address: _____

_____

Yes, I would like my receipt mailed to me for every monthly transaction made: _____

No, please do not mail my monthly receipt to me: _____

2. **Please provide credit card information:**
(All information is this section is required.)

Card Type: ____Visa ____MasterCard ____Discover ____American Express

Print name as it appears on credit card: _____

Billing Address of Cardholder: _____

Credit Card Account Number: _____

Expiration Date: _____ CVV (3 digit security code) #:_____

Process the charge on or about the: ____ 1st of each month ____ 15th of each month

Recurring charge amount: $_____

BE SURE TO READ AND SIGN THE AGREEMENT AND MAKE A COPY OF THIS FORM FOR YOUR RECORDS

3**. Sign:**

I understand that Carolinas Dermatology Group will notify me in advance of any changes to the charged amount of a $1.00 or more. I must give Carolinas Dermatology Group 25 days written notice to stop the charges or to change my credit card account information. By completing this form, I hereby authorize Carolinas Dermatology Group and the credit card company identified on this authorization to process the charges authorized herein. Any new balance(s) occurred after I sign this authorization, I understand that an addendum must be signed in order to add any other charges to this authorization.

Print Name: _____ Date: _____

Signature: _____

Witness Signature: _____ Date: _____