DEDICATED CARE CENTER
Payment Authorization

I, the undersigned authorized user/signer on the account from which funds will be drawn, authorize my bank or credit card institution to honor preauthorized Electronic Funds Transfers (EFT) or charge authorizations, as indicated below, drawn by Dedicated Care Center for Membership Fees and any additional fees incurred pursuant to the Dedicated Care Center Enrollment Form. When the bank or credit card institution honors the EFT or credit card by charging my account, this transfer will constitute notice of payment due and my receipt for the payment. The amount debited via EFT or credit card will be the total due on the 25th day of each month. Should any preauthorized EFT or credit card not be honored by said bank or credit card institution when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus any applicable late, return or other fee. It is further understood that if such payment is not honored by the bank or credit card institution, then Dedicated Care Center, at its discretion, may resubmit the amount due for payment on a future date. This authority is to remain in full force and effect until Dedicated Care Center has received written notification from me of its termination in such time and in such manner that Sentara Medical Group has a reasonable opportunity to act on it.

Patient Name (PLEASE PRINT)

Primary Phone:

Secondary Phone:

Patient Signature_____ Date _____

EFT and Credit Card Options

1. I choose to utilize the EFT option for the monthly payment (direct debit from my Checking or Savings account)

Bank Name _____ Name on Account _____

Routing/Transit Number _____ Account Number _____

Authorized Signature: _____ Date: _____

****REQUIRED: Attach a voided check if using the checking account option and a deposit slip for the savings account option.****

2. I choose to utilize the Credit Card

☐ One time charge

☐ Monthly payment (automatic direct charge to credit card)

☐ One time annual payment

Credit Card Type: ☐ Visa ☐ MC ☐ AMEX ☐ Discover

Name on Credit Card _____ CVV _____

Account Number _____ Expiration Date _____

Authorized Signature: _____ Date: _____

For Office Use Only

Medical Record Number:	**Membership Type:**	**Payment Method: ☐ Checking Account ☐Savings Account ☐ Credit Card**
Effective Date:		**Monthly Fees: $_____**

Keyed By:_____ Date_____

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