

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 Sentara Medical Group, Innovations 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 Sentara Medical Group, Innovations, 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 Sentara Medical Group, Innovations has received written notification from me of its termination in such time and in such manner that Sentara Medical Group, Innovations has a reasonable opportunity to act on it.

Patient Name (PLEASE PRINT)		
Social Security Number	Home Telephone Number	Work Telephone Number
Patient Signature	Date Signed	

ELECTRONIC FUNDS (EFT), CREDIT CARD OR MONTHLY STATEMENT INFORMATION

I choose to utilize the EFT option for the monthly payment (direct debit from my Checking 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.****

I choose to utilize the Credit Card option for the one time annual payment

I choose to utilize the Credit Card option for the monthly payment (automatic direct charge to credit card)

Please keep my credit/debit card information on file to pay for co-payments or account balances

Credit Card Type: Visa MC AMEX Discover Diners Club

Name on Credit Card _____

Account Number _____ Expiration Date _____

Authorized Signature: _____ Date: _____

Billing Address: _____

Authorized Signature: _____ Date: _____

For Office Use Only

Medical Record Number:	Membership Type <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Payment Method	Monthly Fees
Effective Date:	Expiration Date:	<input type="checkbox"/> Checking Account Draft	\$ _____
		<input type="checkbox"/> Savings Account Draft	\$ _____
		<input type="checkbox"/> Credit Card	\$ _____
		<input type="checkbox"/> Monthly Statement	\$ _____

Keyed By: **Date Keyed:**