Payment Authorization

Account Setup and Payment

Primary Enrollee Name: ___________________________________ Age: _____ Monthly Fee:O$80 O$60 O$40 O$10

Monthly fee are $10 for ages birth to 20, $40 for ages 21 to 40, $60 for ages 41 to 64, $80 for ages 65 to 99, $0 for ages 100+

Additional Enrollees:

Name: _____________________________ Age: ___ Relationship: _____________ Monthly Fee:O$80 O$60 O$40 O$10
Name: _____________________________ Age: ___ Relationship: _____________ Monthly Fee:O$80 O$60 O$40 O$10
Name: _____________________________ Age: ___ Relationship: _____________ Monthly Fee:O$80 O$60 O$40 O$10
Name: _____________________________ Age: ___ Relationship: _____________ Monthly Fee:O$80 O$60 O$40 O$10

Total Fees Due at time of Enrollment: $____________

Payment by check, automatic bank withdrawal, or Visa/MasterCard of your first month's membership fee is due with your enrollment forms, along with your authorization for ongoing automatic monthly payments. Please make checks payable to: Vintage Direct Primary Care, PLLC.

Automatic Payment Authorization

• Monthly membership fees will be automatically transferred to Vintage Direct Primary Care, PLLC each month on the same day of the month that my membership was accepted by Vintage DPC (or as soon as practical thereafter) as payment for services for that month's billing cycle.

• I understand that this Authorization will remain in effect until Vintage Direct Primary Care has received written notice from me of cancellation. Membership is month to month. I have the right to stop payment of a specific transfer at least five (5) business days before the next scheduled withdrawal.

• I understand and authorize that a $25 fee will be charged to me for non-sufficient funds or any event preventing payment to Vintage Direct Primary Care, PLLC.

• I understand that the standard recurring transaction amount is the total of my own membership fee plus that of any other individuals named on my account.

Authorization for automatic payment of recurring monthly fee:

# of Children (0 to 20) ____ X $10/mn: $_______ # of Adults (21 to 40) ____ X $40/mn: $_______
# of Adults (41 to 64) ____ X $60/mn: $_______ # of Adults (65 to 99) ____ X $80/mn: $_______
# of Adults (100+) _____ X $ 0/mn: $_______ **Total monthly fee**: $_________

O Credit or Debit Card:

Name on Card: _____________________________ Card Billing Address: ____________________________________
Card Type: O Visa O MasterCard Expiration Date: ____________ ____________________________________
Card Number: __________________________________ 3 Digit Security Code (on back of card): ________

OR

O Banking Account: Voided check attached.

Bank: ____ Name on Account: ______________________________
Routing Number: ________________________________ Account Number: ________________________________

I understand and will comply with the above payment terms. I hereby authorize Vintage Direct Primary Care, PLLC, to initiate credit/debit card transactions or automatic bank withdrawals on a monthly basis for the above total monthly fee. I authorize my financial institution to honor these transfers.

Signature: ____ Date: _______________________

E-mail address: ____