Card on File

Billing Management Inc. Recurring Payment Authorization Agreement

PO Box 085747 • Racine, WI 53408 || questions@billing-management.com || ph (866) 638-7442 || fax (262) 638-7455

Patient Name _____ DOB _____

Clinic Name_____ Provider Name_____

Account Holder Name_____

Billing Address _____

City_____ State_____ Zip Code_____

► CREDIT OR DEBIT

Card Number_____ (Visa or MasterCard ONLY)

Expiration Date_____/_____ CVC Code_____

► CHECKING WITHDRAWAL

Routing Number _____

Account Number _____

There will be **no fee associated with checking withdrawal*

Comment _____

I hereby agree that session copays or missed appointment payments will be processed to the debit or credit card or bank account information (as indicated above) on file for payment. In cases where deductible amounts cannot be confirmed by the insurance provider(s) prior to date of service, I agree a deposit equivalent to the clinician's session rate will be reserved to the debit or credit card or bank account information (as indicated above) on file for payment. In cases where the session's deductible amount is confirmed as less than the session rate, the deposit will be processed as a refund to the debit or credit card or bank account information (as indicated above) on file within 7-10 business days.

I hereby authorize Lighthouse Clinic LLC and Billing Management Inc. to keep my debit or credit card or bank account information (as indicated above) on file for payment and to Initiate appropriate payment entries against the above-referenced debit or credit card or bank account, as applicable, as amounts are owed by me on the patient account listed above. I acknowledge that the Initiation of all such entries to make payments on the patient account listed above must comply with the provisions of US law and any applicable state laws. I understand and agree that these entries may be made to my debit, credit card, or bank account, as applicable, periodically to pay amounts owed by me on the patient account listed above. I also agree to notify Lighthouse Clinic LLC or Billing Management Inc. if my debit card, credit card, or bank account information (as indicated above) changes for any reason. This authorization shall remain in effect until the end date of authorization listed above or until I communicate to Billing Management my Intention to cancel this authorization by calling or writing to the phone number or address listed above. I acknowledge receipt of a copy of this authorization form. I understand that my payment will show on my Credit/Debit/Flex/HSA statement as “Billing Mgt 8666387442 Med Serv” or on my Banking Statement as “MedPmt2626387442." If my payment is reversed for any reason, or if my checking account declines the transaction, I understand a $35 chargeback fee will be applied to my account.

Cardholder Signature _____ Date _____