



## Pre-Authorized Payment Form (confidential when complete)

Your name: \_\_\_\_\_

University OB/GYN Account #: \_\_\_\_\_ Main Telephone #: \_\_\_\_\_

### 1. PLEASE CHECK ONE:

- New Enrollment in Pre-Authorization Payment Plan
- Make changes to an existing Pre-authorized Payment Plan

### 2. PLEASE INDICATE YOUR PAYMENT METHOD:

- Credit Card (Please provide Credit Card Information)
  - Visa
  - MasterCard Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
- Commercial Insurance Card (please indicate carrier) \_\_\_\_\_

### 3. WITHDRAWAL INFORMATION:

Preferred Payment Date: (optional) \_\_\_\_\_ (1-30) day of every month

Payment Amount: \$ \_\_\_\_\_

I hereby authorize University OB/GYN Associates, PSC and the credit card issuer indicated to release funds for payments for billed charges under the terms and conditions of this request. All terms are subject to cardholder's agreement with my financial institution.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Daytime contact number: \_\_\_\_\_

### TERMS AND CONDITIONS

1.) I understand that this authorization to University OB/GYN is exactly the same as if I authorized the credit card institution or the branch of my bank/financial institution where I keep the bank account. The credit card institution or bank branch will treat every withdrawal or debit as though I had personally directed them to make payments, and will charge the specified amount to my account.

2.) I will let University OB/GYN know, in writing, of any changes in the credit card or account information or my pre-authorized payment does not cancel my service with University OB/GYN, nor does it end my obligation to pay University OB/GYN in the normal fashion.