Authorization for Recurring Credit Card Payment

I _____ ***(Print Patient Name)*** authorize the **OB-GYN Health Center of Volusia, LLC** to regularly charge my credit card for the amount indicated below each billing period. The charge will appear on your credit card statement. You agree that no prior-notification will be provided unless there are any changes to the agreement listed below.

I _____ authorize **OB-GYN Health Center of Volusia, LLC**
(Cardholder's Name) (Merchant's Name)

to charge my Credit Card indicated below for $ _____ on the _____
(Amount) (Day)

of each _____ until the amount owed of $_____ is paid in full.
(week, month, etc) (Balance due)

Billing Information:

Billing Address _____ Phone# _____

City, State, Zip _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify ***OB-GYN Health Center of Volusia, LLC 769 N. Clyde Morris Blvd Daytona Beach, FL 32114*** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Cardholder's Signature)