Summit Medicine and Pediatrics PLC
PATIENT PAYMENT UPDATE: CC

Pioneers in Direct Access Medicine©

CREDIT CARD PAYMENT INFORMATION UPDATE AUTHORIZATION

Thank you for agreeing to update your credit card payment information. Upon completion and return of this authorization, your credit card payment information will be integrated into our secure, automated merchant service and banking system. **In accordance with federal law, we require your signature to authorize all changes and updates in credit card payment information in order to continue payment for services, and all changes and updates shall apply to all patient accounts for whom you have agreed to make payment for services rendered.**

At your earliest convenience, please take a moment to review the credit card payment information given to us, and **sign** and **return** this document to us.

Credit Card: Name on Card:____

Type: (circle one) VISA MC AMEX Exp. Date:_____________

Card Number:______________________________ CVV:_______________

Billing Address:____

Billing Zip Code:____________________

This payment information applies to services rendered for the following patients:

Name:____ DOB:_______________

Name:____ DOB:_______________

Name:____ DOB:_______________

Name:____ DOB:_______________

I attest that the payment information above is accurate and complete and authorize Summit Medicine and Pediatrics PLC to continue to charge my credit card according to the terms and conditions previously acknowledged for services rendered.

Signature:____ Date:_______________

Name:____

INSTRUCTIONS: Once you have completed and signed this form, please fax the form to us at 480-656-0098, or mail the form to us at: Summit Medicine and Pediatrics, 6828 E. Brown Rd., Ste. 102, Mesa, AZ, 85207

Internal use only:

[ ] Initial__________ [ ] Update_________

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