Rocky Mount Family Medical Center

Credit Card Authorization Form
For Recurring Payments

Chart #_____

Please fill in the information and sign below.

Print Name_____

Phone Number_____

Email_____

Credit Card Type (Check One) ___Mastercard ___ Visa ___Discover

Credit Card Number_____-_____-_____-_____

Security Code_____

Expiration Date ___/___

Credit Card Holder's Name (print)_____

Billing Address_____

City_____ State _____ Zip _____

Card Holder Phone Number _____

I authorize Rocky Mount Family Medical Center to initiate a recurring payment to the credit card indicated above for the minimum payment of $_____ each month on the ____ day of the month (or within a couple of days due to weekends) I also authorize charges for any additional related services that I may incur.

I understand that I may cancel my recurring payment upon written notice to Rocky Mount Family Medical Center Billing Department allowing thirty days (30) time for action on my cancellation notice.

Card Holder Signature_____Date_____

Highly Confidential