RECURRING PAYMENT AUTHORIZATION FORM

Date:	Member Name:		
Physical Address:	City:	State:	Zip:
Mailing Address: ☐ Same	City:	State:	Zip:

Main Phone #: ( )	Alt. Phone#: ( )	Fax #: ( )
Email address:		

CREDIT CARD PAYMENT INFO

Card Number:		
Exp Date:		
CVS Code:		
Name On Card:		

Automatic monthly payment by credit card or debit card is required to enroll in Direct Primary Care Membership.
By filling out and signing this form you are giving authorization for Faith Immediate Care to charge your account for the amount indicated on this form on the date indicated on this form. You may cancel this automatic payment authorization at any time by contacting us.

AMOUNT DUE UPON ENROLLMENT

Enrollment Fee: $25.00

Monthly Fee: $39.00

Total $64.00

Date Charged: ____________________

How did you hear about us?: (Please check one)

☐ Commercial
☐ Website Referral*
☐ Mail Out
☐ Current Client*
☐ Insurance Agent*
☐ Search Engine*
☐ Other

* Please List Name of Referrer

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____________________________ ______________
Signature Date

☐ Notify me via email when my credit card/debit card is charged. (make sure email address above is correct.)