Recurring Credit Card Payment Authorization

By signing below, you authorize Ferman Optometry, P.C. to make regularly scheduled charges to your credit card. Your credit card will be charged the amount indicated, once per month, on the pay date indicated. If the pay date falls on a day when the office is closed, your card will be charged on the next day that the office is open. Ferman Optometry, P.C. will provide a receipt for each payment received.

Recurring charges for a given Date of Service (DOS) must be scheduled such that the balance is paid in full no later than 180 days from the initial DOS. Any payment plan that extends beyond 180 days must be approved by Dr. Ealovega. If you wish to cancel this authorization, written notice must be received by Ferman Optometry, P.C. no later than three (3) business days prior to the scheduled pay date.

This paper authorization and an image of your credit card will be scanned as separate files into our secure electronic health record system. The image file of this authorization form will be retained indefinitely. When all payments have been made and the balance is paid in full, or if a written notice of cancellation is received, your credit card image file will be permanently deleted from our records.

Patient: _____ ; DOS _____ Invoice# _____
(print patient name) (MM/DD/YY)

I,_____ authorize Ferman Optometry, P.C. to charge my
(print card holder's name)

credit card indicated below for $_____ on the _____ of each month, starting with
(recurring amount) (pay date)

the month of_____. Total # of payments authorized: _____

Preferred receipt delivery (circle one) paper receipt via mail scanned receipt via e-mail

Credit Card Billing Information

Card Type (circle one) Amex Discover MasterCard Visa

Billing Address _____ Phone #_____

City/State/ZIP _____ email _____

I agree to and understand all of the following… no further notification from Ferman Optometry, P.C. is required, unless there is a change in the amount being charged; this authorization will remain in effect until all payments indicated above have been made, or until I cancel it in writing; if this authorization is cancelled before the balance is paid in full, the balance will be due immediately; there will be zero monthly finance charges, provided that the balance is paid in full within 180 days from the DOS; if the balance is not paid in full within 180 days from the DOS, I will be charged a $15 finance fee in addition to the outstanding balance. I acknowledge that the origination of credit card transactions must comply with the provisions of U.S. law. I certify that I am an authorized user of the credit card indicated above and that I will not dispute these scheduled transactions; so long as the transactions correspond to the terms in this authorization.

_____ _____
(cardholder signature) (date)