Dominion Primary Care
WHAT PRIMARY CARE SHOULD BE

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Upon approval, you will have the option to make monthly payments or set up a monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic statement sent to your email. Your statement will include monthly fees and incidental charges, which you will receive prior to any payments or deductions.

Customer(s)Name(s):

_____

_____

PAYMENT INFORMATION

I authorize Dominion Primary Care to automatically bill the card listed below as specified:

Amount: $_____   ☐ Incidental Charges (please check for lab/imaging charges)

Frequency: ☐ Monthly   ☐ Quarterly   ☐ Bi-Annually   ☐ Annually

Start billing on: ____/____/____   **End billing when**: Customer provides written cancellation

CREDIT/DEBIT CARD INFORMATION (Visa, MasterCard, American Express, Discover)

Credit card type: _____ Credit card number: _____ Expires: ____/____

Cardholder's name: _____ CVC (Security code) _____
(As shown on credit card)

Customer's signature: _____ Date: _____