Payment Authorization

DR CRANNEY
FAMILY MEDICINE

Account Setup and Payment

Primary Enrollee Name: _____ DOB: _____

Monthly Fee: O$69 O$39 O$175 Fam

Monthly fees are $39 for ages 29 and below, $69 for ages 30-59, $99 for ages 60 and above, $175 for a family (2 adults and 2 children) with $29 each additional child Additional Enrollees:

Name: _____ DOB: _____ Relationship: _____ Monthly Fee: O$99 O$69 O$39 OFam

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Total fees due on initial date of service: $_____

Payment by check, automatic bank withdrawal, or visa/MasterCard of your first month's membership fee is due with your enrollment forms along with your **authorization for ongoing automatic monthly payments. Please make checks payable to: Dr Cranney Family Medicine, PLLC.**

Automatic Payment Authorization

- **Monthly membership fees will be automatically transferred to Dr Cranney Family Medicine, PLLC each month on the same day of the month that my membership was accepted by Dr Cranney Family Medicine (or as soon as practical thereafter) as** payment for services for that month's billing cycle.
- **I understand that this Authorization will remain in effect until Dr Cranney Family Medicine has received written notice from me of cancellation. Membership is month to month. I have the right to stop payment of a specific transfer at least five (5) business days before the next scheduled withdrawal.**
- **I understand and authorize that a $25 fee will be charged to me for nonsufficient funds or any event preventing payment to Dr Cranney Family Medicine, PLLC.**
- **I understand that the standard recurring transaction amount is the total of my own membership fee plus that of any other individuals named on my account.**

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Authorization for automatic payment of recurring monthly fee:

Family Plan	**_____ x $175/month**
Each additional child	**_____ x $29/month**
# of members 29 or less	**_____ x $39/month**
# of members 30-59	**_____ x $69/month**
# of members 60 or greater	**_____ x $99/month**

TOTAL MONTHLY FEE: $_____

O Banking Account: Please attach a voided check.

Bank: _____

Name on Account: _____

Routing Number: _____

Account Number: _____

- OR - O

Credit or Debit Card information:

Name on Card: _____

Card Billing Address: _____

Card Type: O Visa O MasterCard OAE Expiration Date:_____

Card Number: _____ 3 or 4 Digit

Security Code: _____

I understand and will comply with the above payment terms. I hereby authorize Dr Cranney Family Medicine, PLLC, to initiate credit/debit card transactions or automatic bank withdrawals on a monthly basis for the above total monthly fee. I authorize my financial institution to honor these transfers.

Signature: _____ Date: _____

E-mail address: _____