Payment Authorization Agreement

Patient or Guarantor Name: _____

Date of Birth: _____

Phone Number: _____

Agreement Terms

1. **Initial Payment**
   I understand that a non-refundable initial payment is due at check in. This payment is **subject to, but not limited to, co-pays, deductibles, sliding fee and self-pay fee.** I understand that it is separate from any additional charges that may apply after my visit.

2. **Card on File Authorization**
   To facilitate payment for any remaining balances after my visit, I authorize Midwest Refuah Health Center to keep my credit/debit card information on file. I agree that any additional charges, co-pays, or balances owed after my visit will be automatically charged to the card provided below.

   Cardholder's Name: _____

   Card Type: (Visa / MasterCard / American Express / Discover)

   Last 4 digits: _____

   Expiration Date: _____

   Billing Address ***(if different than one on file):*** _____

   City/State/Zip Code: _____

3. **Right to Update Payment Information**
   I understand that I may update my payment information at any time by contacting Midwest Refuah Health Center directly.

Consent

By signing this form, I acknowledge that I have read, understand, and agree to the terms outlined above. I consent to having my credit/debit card information stored securely by Midwest Refuah Health Center and used for future payments as described in this agreement.

Patient/Guarantor Signature: _____ **Date:** _____

Authorized Rep Signature ***(if applicable)*****:** _____ **Date:** _____