KC D PC

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To facilitate automated billing, complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Information can be later updated via secure link accessed through your electronic statement sent to your email. Your statement, which you will receive on the date of your payment/deductions, will include monthly fees and incidental charges.

Patient(s) Name(s): _____

_____

I authorize KANSAS CITY DIRECT PRIMARY CARE to automatically bill and charge the card listed below as specified on a MONTHLY basis:

Incidental charges (labs, medications, medical supplies, etc.) and $_____

for medical services.   *Note: annual subscriptions available at a discount.*

Start Date: _____/_____/_____   **End Date:**   Upon cancellation

CREDIT/DEBIT CARD INFORMATION

Card Number: _____

Expires: _____/_____   CVC (Security Code): _____

Cardholder's Name (as it appears on the card):

_____

Customer's Signature: Date:

_____   _____

Is this credit card different than the one used to sign up online?   [ ] YES or   [ ] NO

Alternatively, you may pay using your bank account via monthly ACH withdrawal -- which helps us keep costs down! Please ask a KCDPC staff member for the appropriate form.

KC D PC

AUTOMATIC RECURRING ACH WITHDRAWAL AUTHORIZATION

To facilitate automated billing, complete the ACH Information section below and sign the form. All requested information is required. Information can be later updated via secure link accessed through your electronic statement sent to your email. Your statement will include monthly fees and incidental charges, which you will receive on the date of your payment/deductions.

Patient(s) Name(s): _____

_____

I authorize KANSAS CITY DIRECT PRIMARY CARE to automatically bill and charge the account listed below as specified on a monthly basis:

Incidental charges (labs, medications, medical supplies, etc.) and $_____

for medical services.   *Note: annual subscriptions available at a discount.*

Start Date: _____/_____/_____   **End Date:**   Upon cancellation

ACH INFORMATION:

Bank Routing Number:

_____

Account Number:

_____

Account Holder's Signature: Date:

_____   _____

The ACH setup process is not complete until you have verified your account. Our software, Atlas.md, will verify ownership of this account by making two small deposits into your account within two business days of getting your account set up. The charge description should read VERIFICATION and the amount on each of these deposits will work as the verification key to confirm your ownership of the bank account. We will send you an email shortly with details about this process along with a link you may use to complete the verification process.   If you have any trouble with this, please call us and we can manually enter the two small amounts! **NOTE: If you do not verify your account, we will charge the card on file that was used during your enrollment process for the above.**