



P.O. Box 89, Chehalis, WA 98532
Phone 360-740-0888 Fax 360-740-0555

Payment Authorization

Member Name: _____

Address: _____

Street Address

Billing Address (if different from Street Address)

City

State

Zip

Billing Phone: () _____ Alt. Phone: _____

Billing Contact: _____

Billing E-Mail: _____

I, _____ Representing _____
Name Billing Name

hereby authorize a recurring charge to the listed credit card of:

_____ \$45.00 per month per enrollee (1st two) _____ \$55.00 per month per enrollee (1st two)(Extended Lab/X-ray)
_____ \$30.00 per month per child enrollee (0-18 yrs) _____ \$40.00 per month per child enrollee (Extended Lab/X-ray)

to be billed *after* the completion of the calendar month for which a DirectCareMD Agreement is in force (credit card is usually charged within the first 5 days of the next calendar month).

The initial number of enrollees is: _____ Notice to DirectCareMD from time to time of additional enrollees or discontinued enrollees shall constitute a modification of this request to adjust the monthly billing accordingly.

TOTAL INITIAL AUTHORIZED CHARGE: \$ _____

The credit card to be billed is: _____ MC _____ VISA _____ AE _____ DISCOVER

Credit Card Number is: _____ Exp: _____

NOTE: This charge will be processed by and the entry on your statement will read "DirectCareMD"

I have read and understand the DirectCareMD Agency Agreement, herein incorporated by reference, and agree to its terms.

Member Printed Name

Member Signature

Date

Acknowledged on behalf of DirectCareMD by:

Name

Position
