Michael Frampton, M.D., P.C., *American Board Certified in Psychiatry*
9120 Connecticut, Suite A, Merrillville, IN 46410
Phone: 219-793-1233 Fax: 219-793-1244

CREDIT CARD PAYMENT AUTHORIZATION

Check One (1) of the Following Options and Enter Your Details:

☐ **Option 1: Recurring Charge** - You authorize regularly scheduled charges to your credit card or bank account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card or bank statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I, ________________________________, authorize Michael Frampton MD, PC to charge my
(Full Name)

Credit Card below for $ _____________ on the ___________ of each _____________.
(Amount $) (Day) (Week, Month, etc.)

This payment is for **balance due at Michael Frampton MD, PC**

All future visits must be paid in full according to your insurance benefits or self pay rate. This final notice on the account will be removed once this contract is signed and returned. However, if the card does not go through, then we will call you. If we do not get a hold of you, we will send a final notice.

☐ **Option 2: One (1) Time Charge** – Sign and complete this form to authorize the merchant below to make a one-time charge to your credit card or bank account listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I, ________________________________, authorize Michael Frampton, MD, PC to charge my
(Full Name)

Credit Card below for $ _____________ on the ___________ of each _____________.
(Amount $) (Day) (Week, Month, etc.)

This payment is for **balance due at Michael Frampton MD, PC**

Continue to billing information on the next page…

Credit Card Payment Authorization (cont. page 2)

Billing Information:

Billing Address: _____

City: _____ State: _____Zip: _____

Phone: _____ Email: _____

Credit Card Information:

☐ Visa ☐ MasterCard ☐ AmericanExpress ☐ Discover

Cardholder Name: _____

Account Number: _____

Exp. Date: _____ / _____ CVV: _____

* I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

** If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the merchant may at its discretion attempt to process the charge again within 30 days, and agree to an additional $_____ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

If the card does not go through, we will call you. If we can't get ahold of you or you do not reply within 7 days, we will send a final notice.

AUTHORIZED SIGNATURE: _____

PRINT NAME: _____ Date: _____

***This payment plan will remain in effect until the balance is paid in full or we receive a cancelation notice in writing from the authorized party above.**

****In the event the scheduled date falls on a day our office is closed, the charge will be processed on our next business day.**

Please email this back to billing@michaelframpton.com or fax to 219-793-1244.
This form can be mailed to 9120 Connecticut Dr., Suite A, Merrillville, IN 46410