



830 EYRIE DR. SUITE 6B  
 OVIEDO, FL 32765  
 PH# 800.330.2313  
 Fax # 407.365.0774 or  
 866.413.5202

**Payment Authorization Form**

**Check One** →    **Payment Arrangements** \_\_\_\_\_    **One Time Only Payment** \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 CMSI Account #: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State/zip \_\_\_\_\_

**Name and Address of the Credit Card Account Holder (Billing address of credit card)**

\_\_\_\_\_  
 \_\_\_\_\_

**Credit Card (circle one) : Visa / Mastercard**  
**Institution Name :** \_\_\_\_\_  
**Credit Card Account Number** \_\_\_\_\_

**Exp. Date:** \_\_\_\_\_ **3 Digit Security Code on Back of Card** \_\_\_\_\_

**I hereby authorize CMSI to charge my Credit Card listed above in the amount of :**

\$10    \$20    \$50    other \_\_\_\_\_ *(greater than \$75)* on this date each month \_\_\_\_\_ **OR on this date** \_\_\_\_\_ **(one time payment)**

I agree that each charge to my account shall be the same as if I had signed a check to pay my account. I understand that it is my responsibility to notify **CMSI** in writing if I change my credit card information, address and phone number. This authorization will remain in effect until either party gives written notice to the other of termination. I understand my notice of termination must be received in time to have reasonable opportunity to act. If my credit card is declined for whatever reason, I understand that **CMSI** will attempt to contact me for alternate payment arrangements. I understand if charges are denied 3 times within 12 months a penalty fee of \$35.00 will be applied to my balance.

By signing this authorization, I acknowledge that I have read and agree to all of the above.

**Print name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_