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 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:** _____