PAYMENT AUTHORIZATION FORM

I authorize MJHaber, MD, LLC to regularly charge by Visa and Mastercard for services rendered under this contract.

I authorize MJHaber, MD, LLC to charge my card for missed appointment fees, late cancellation fees, and balance of fees defined by my insurance company, and not paid by my insurance company within 30 days of date of services provided, and insufficient check amounts plus insufficient check fees of $50.00 per bad check

If you have questions about these charges, I agree to contact MJHaber, MD, LLC. I agree that I will not pursue a refund directly with my credit card company, bank institution, or other financial institution for charges listed above and services rendered. If any of my actions yield a chargeback for any reason, I agree to pay any fees to my lenders as a result. I understand that if I do not pay balances withing 30 days, I will be sent to collections.

Account Type (VISA, Mastercard): _____

Name on Card: _____

Account Number: _____

Expiration Date: _____

CVV (3-digit on back): _____

Card Billing Address: _____

By submitting this form, I authorize MJHaber, MD, LLC to charge my credit card as indicated in this authorization from according to the terms and conditions outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify MJHaber, MD, LLC of any changes to my account information or termination of this authorization at least 15 days prior to the next appointment. I certify that I am the authorized user of this credit card, and I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the conditions outlined in this authorization from.