Recurring Credit Card Charge Authorization Form

I (we) hereby authorize Associates in Family Practice of Broward, LLC(DBA Associates in Family Practice) to make recurring charges to my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Associates in Family Practice is notified by me (us) in writing to cancel it in such time as to afford Associates in Family Practice and Credit Card company a reasonable opportunity to act on it.

_____

(Name - PLEASE PRINT AS APPEARS ON CARD)

_____

(Address - PLEASE PRINT)

_____

(Phone Number - PLEASE PRINT)

_____

(Email - PLEASE PRINT)

Please circle one: Visa / MasterCard

Account Number: _____

Expiration Date:_____

Charge Amount: $_____

Frequency (please circle one or fill out your own schedule):
Bi-monthly Monthly Quarterly or _____

_____ _____

(Signature) (Effective Date)

Please return to:

Associates MD
4801 S. University Dr. Suite 104
Davie, Fl 33328

Fax: 954.434.1882
Phone: 954.434.1705
www.AssociatesMD.com