PRECISION

REGENERATIVE & FUNCTIONAL MEDICINE

AUTOMATIC BILLING AUTHORIZATION FORM

Company Name: **Precision Regenerative and Functional Medicine** ID Number: _____

FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card(s) listed below:

Primary Card Account	**Secondary Card Account**
Name on credit card (exactly as printed)	Name on credit card (exactly as printed)
Billing Address for credit card (Street, Apt. #)	Billing Address for credit card (Street, Apt. #)
City, State Zip	City, State Zip
Credit card number Expiration Date	Credit card number Expiration Date
Signature Today's Date	Signature Today's Date

☑ Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date.

☑ This authorization is valid until I provide you with written cancellation.

- I authorize the charge of all copays, co-insurance or deductible amounts due for all in office and telemedicine visits.
- I authorize the charge of all No-Show or Missed appointment fees. I have reviewed and signed the Cancelation and No-Show Polices and Fee document.
- I authorize the charge for all clinic lab fees for labs drawn at PRFM.
- I authorize the charge for any peptides, HRT products that are ordered and paid for by PRFM and shipped directly to my home.
- I authorize the charge for any unpaid balances over 30 days old.

Patient signature:_____ Date:_____

1101 S. Capital of Tx Hwy F-101 Austin,TX 78746 phone 512.892.0490 facsimile 512.892.0589