Secure Payment Method Authorization Form

This form is to authorize Family Medicine of Michigan to capture a secure payment method and to charge an amount that has been deemed payable for services rendered to that payment method in accordance with Family Medicine of Michigan's Practice Financial Policy.

By Signing below I agree to the following:

1. I understand that my signature and payment information (Secure Payment Method) will be maintained on file for current and future use by Family Medicine of Michigan. The applicable payment method, card numbers, account numbers and security codes will be truncated and "Tokenized" by Navicure Payment Solutions, the designated payment agent for Family Medicine of Michigan, in order to maintain the security of my payment information.
2. I authorize Family Medicine of Michigan to charge my payment method for amounts owed now or at a future date. These charges would be in accordance with the Practice Financial Policy and used to pay for services for things such as medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance, (iv) amounts not covered by insurance, (v) and or fees charged by the practice for failure to provide timely notice of appointment cancelation and other fees for administrative services such as forms, records, statement fees, etc.
3. I authorize Family Medicine of Michigan to send electronic account statements to my email address on file in accordance with the Practice Financial Policy. I understand that I may not receive a copy of such invoice or statement via U.S. Mail but that any time a statement is generated due to an outstanding balance there will be a $5 charge applied to my account. I understand that it is my responsibility to maintain a current email address on file with the practice.
4. This authorization will remain in effect until I provide written notice of cancellation to the practice. I understand that I can cancel the authorization only for future services. Authorization for services already rendered cannot be cancelled or rescinded.
5. I agree to notify Family Medicine of Michigan of any changes in my payment information such as expiration dates, card type or number changes, security code changes, etc.
6. I authorize Family Medicine of Michigan to process payments without advance notice up to a maximum of $500.00 per occurrence. An attempt to notify me of a pending payment via the email I provide here will be initiated by Navicure Payment Solutions, but I understand that a notification is not guaranteed and I agree that prior notification is not a condition of the payment being processed.

I understand the above and hereby authorize Family Medicine of Michigan to use my secure payment method on file as outlined above for the below Patient.

_____	_____	_____	_____
Last 4 digits of Card/Account	Expiration	Patient ID#	Family Account #

_____	_____
Card/Account Holder Phone Number	Card/Account Guarantor Email Address

_____	_____
Card/Account Holder Signature	Date