Payment Authorization Form

Account Name: _____

EIN/NPI:_____

Please state total monthly amount in US Dollars for the account (s) that are active and you utilize under Inmediata. Inmediata Health Group will perform an ACH debit transaction for the amount you specify in total on a monthly basis and/or when invoice payment is due.

Monthly Charge $ _____

Accountholder Name: _____

Bank Account Information:

Bank Account # _____

(ABA):_____

Account type: Check ☐ Savings ☐

Credit Card Information:

Credit Card #_____

Exp Date: ___/_____

CVV :_____

Comments:

Account payable information:

Contact billing name:_____

Billing Address:_____

City:_____State:_____ Zipcode:_____

Phone:_____ Email:_____

DISCLAIMERSTATEMENT:
Being the accountholder, by signing below I understand and agree to the terms set forth in this agreement, agree to pay and specifically authorize lnmediata Health Group. To debit my bank account for the services provided. I further agree that in the event my bank account or credit card becomes invalid, I will provide lnmediata Health Group with a new valid bank account or credit card upon request, to be charged for the payment of any outstanding balances owed to lnmediata Health Group. For bank accoun debits: In the event a charge is returned by insufficient funds, I authorize to process an automatic new debit as many times as deemed necessary.

I understand that ther willalsobe a charge of $25.00 forevery charge returned by the bankand a reconnection fee of $50.00.A $10.00 Monthly processing fee will be applied to customers paying by check.

I understand and agree to the aforementioned terms and conditions:

Provider Printed Name:_____

Provider Signature:_____Date:_____

Send the form by email to: contabilidad@inmediata.com