PREMIER PERSONAL HEALTHCARE

CONCIERGE INTERNAL MEDICINE
www.warshawmd.com | 412-833-2233

## PAYMENT OPTION / AUTHORIZATION FORM

Pursuant to the terms and conditions of my Patient Agreement with Premier Personal Healthcare, LLC ("PPH"), I/we hereby authorize PPH to debit the amount of the Fees as provided below for my benefit. Until Patient/Member notifies PPH otherwise, this authorization will not expire.

I choose to make payment as indicated below:

I. **Frequency (CHECK ONE)**.

❑ **One Time Annual Payment** (offered with a 5% discount)

❑ **Monthly** (Annual Fees divided by 12)

II. **Method (CHECK ONE)**.

❑ **Continue Current Payment Method**

❑ **Credit Card / Debit Card / Check Card**

❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

_____ _____ _____
Credit Card Number Expiration Date 3/4-digit Security Code

❑ **Checking Account Debit**

_____ _____
Routing/ABA Number Checking Account #

❑ **Submission of Monthly Check** – Please make check payable to Premier Personal Healthcare, LLC

**PATIENT(S): Please print name, date and sign below**

_X_____ _____ _____
**Signature** **Printed Name** **Date**

_X_____ _____ _____
**Signature** **Printed Name** **Date**

_____ _____
**Telephone Number**

_____ _____
**Billing Address** **Email**