**PREMIER PERSONAL HEALTHCARE**
CONCIERGE INTERNAL MEDICINE

**www.WarshawMD.com**

## PAYMENT OPTION / AUTHORIZATION FORM

Pursuant to the terms and conditions of my Patient Agreement with Premier Personal Healthcare ("PPH"), I/we hereby authorize Premier Personal Healthcare to debit the amount of the Fees as provided below for my benefit. Until Patient/Member notifies PPH otherwise, this agreement/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 by check, 2% discount by credit card)

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

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

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

❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

________________________________ Credit Card Number

__________________ Expiration Date

_________________ 3/4-digit Security Code

❑ **Submission of Monthly/Yearly Check** – Please make check payable to Premier Personal Healthcare

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

X______________________________ **Signature**

________________________________________ **Printed Name**

__________________ **Date**

X______________________________ **Signature**

________________________________________ **Printed Name**

__________________ **Date**

_________________________________

_________________________________

_________________________________ **Billing Address**

________________________________________ **Telephone Number**

________________________________________ **Email**