AMIC
Advanced Medical
Imaging Consultants, P.C.

2008 Caribou Drive
Fort Collins, CO 80525
(970) 484-4757

Recurring Payment Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.

Authorization Agreement

How Recurring Payments Work:

You authorize monthly scheduled charges to your credit card. Each billing period, you will be charged the amount indicated below. If new charges are incurred, please make sure to call our billing office to include the new charges to the recurring payment plan. You agree that no prior-notification of the payment will be provided unless the date or amount changes.

Patient Account #_____ ◯ QAMIC ◯ QHARM

Patient's Name _____ Phone # _____

Billing Address _____ City, State, Zip _____

I, _____ authorize Advanced Medical Imaging Consultants to charge my credit card indicated
(Name as it Appears on Credit Card)

below on the _____ day of each month for payment on the account listed above. I authorize the following payment plan for the total amount of $_____ ◯ 3-month ◯ 6-month ◯ Other (Please contact Office for approval).

Account Type: ◯ Visa ◯ Master Card ◯ Discover

Account Number: _____

Expiration Date: _____ CVV: _____

Address associated with card (If different from patient's address)

_____

Signature _____ Date_____

I understand that this authorization will remain in effect until the balance has been paid in full or I call the billing office to cancel the recurring payments. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that if the card is declined for any reason, the recurring payments will be dropped, and it will be my responsibility to contact the billing office or to pay my balance via another method.

Please Sign and Mail to:

Advanced Medical Imaging Consultants

2008 Caribou Dr. Fort Collins, CO 80525

OR Fax To: 1 970-484-4759