

Auto Payment Authorization Form

The following authorizing signature does hereby authorize Davies Clinic, PC to debit the listed credit/debit card for the monthly payment indicated and to credit the account listed below. A request must be submitted in writing to revoke this authorization.

Patient Name: _____

Credit Card Type: _____

Credit Card Number: _____

Expiration Date: _____

Security Code if available (three-digit code on back of card): _____

Name on Card: _____

Monthly Payment Amount: \$ _____

Monthly Payment Date: \$ _____

Name and Phone Number of Person Authorizing: _____

Receipt: Yes No

Address to Mail Receipt (if different than account address):

Authorizing Signature: _____

Date: _____

Upon completion, please return this form to:

Davies Clinic - Billing
345 N Grant St
Canby, OR 97013

If you have any questions regarding this form, please contact the billing office at 503.263.4757.