Dannielle Harwood, M.D.
Women's Health & Family Medicine
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CREDIT CARD AUTHORIZATION FORM

TANCS Fee

Please read *Studio+MD Practice Policies* for a full explanation of this fee.

The fee is paid annually. Currently the fee is $250 for the first member of a household and $200 for all others. We do not charge for children ages 16 and under. You may cancel at anytime by providing a 30 day written notice to the address listed above. If you have paid in full for the year, the monies for unused months will be returned to you, minus the months you are an active patient of the practice.

Names of family members enrolled:

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

Name: ____________________________________

I____ authorize Dannielle Harwood, M.D./StudioMD to keep my signature on file and to charge my account for the above named fees.

Patient Name: ____

Card Holders Name: ____

Credit Card Billing Address: ____

Circle One: VISA MASTERCARD

Card Number: ______________________________________Exp Date: ________

CVV: _____

(3 or 4 digit code on back)

Signature: ____ Date: ________________

Account Balance Automated Billing

As you know, if you have ever checked into a hotel or rented a car, you are always asked for a copy of your credit card information, which is then used to pay any remaining balances. At StudioMD, I am requesting the same courtesy to ensure prompt payment for any outstanding charges. By filling out this form, you allow me to spend less time and effort collecting outstanding balances, and have more time to focus on your healthcare needs.

Your credit card information will be held in the same secure manner in which all your personal health information is kept. After I have billed, collected and confirmed accuracy of all insurance payments, I will automatically charge any balance that is your responsibility to your credit card, and send you a copy of the charge. In addition to helping me reduce administrative work-load, it will also save you time and effort, while ensuring all your bills have been paid. You may notate a maximum amount I can charge on your card per month. You may cancel automatic billing at any time by providing 30-day written notice to me at the above address.

Sincerely,

Dannielle Harwood, M.D.

I____ authorize Dannielle Harwood, M.D./StudioMD to keep my signature on file and to charge my account for any outstanding balances for which I am responsible.

No charge will exceed___________ $ per month.

I understand that this form is valid until I give 30-day written notice of cancellation to Dannielle Harwood, M.D./StudioMD

Patient Name: ____

Card Holders Name: ____

Credit Card Billing Address: ____

Circle One: VISA MASTERCARD

Card Number: ____Exp Date:________

CVV: _____

(3 or 4 digit code on back)

Signature____: Date:_________________

I decline:

Signature____: Date:_________________