CONSUMER Credit Card PAYMENT AUTHORIZATION FORM

Jack L. Koch Jr., M.D., PLLC
1507 16th Avenue S.
Nashville, TN 37212
(615) 515-7775

I (we) authorize Jack L. Koch Jr., M.D., PLLC to electronically charge my (our) credit card account (And, if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

Credit Card Type *

VISA
Master Card

I authorize electronic ACH debits / credits to the depository financial institution named below ("DEPOSITORY"). I (we) agree that ACH transactions I (we) authorize comply with all applicable law.

Patient Name (if different)

First Name   Last Name

Name on Card *

Credit Card Number *

Expiration Date *

CVV *

Billing Zip Code *

I (we) understand that this authorization will remain in full force and effect until I (we) notify Jack L. Koch Jr., M.D., PLLC in writing that I (we) wish to revoke this authorization. I (we) understand that Jack L. Koch Jr., M.D., PLLC requires at least 15 days prior notice in order to cancel this authorization.

Dates and/or Frequency of Debits *

With provision of treatment services

I certify that I am an authorized signer for the account indicated above and that I have the authority to authorize this/these transactions. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted transaction date, and that I will have limited time to report and dispute errors. I agree not to dispute this transaction with my bank provided the transaction corresponds to the terms indicated in this authorization form.

I agree to the terms and conditions described above. *

Yes

Name *

Prefix First Name Middle Name Last Name Suffix

Date *

Month Day Year