LORIA MEDICAL PLLC

3625 NW 82nd Ave Ste. 402 Miami, Florida 33166
Email: comp4@loriamedical.com
Office PH: (786) 409-5911 Fax (786) 409-5942

Rev 12-7-16

Credit / Debit Card Authorization Form

_____*One Time Deposit* ___ *Recurrent* Credit / Debit Card Payment

Complete, Sign, Date, and **Fax (or Scan and Email) this form to LORIA MEDICAL** (Fax # and Email address listed above). This form will authorize **LORIA MEDICAL** to make a one time and/or recurrent debit(s) to your credit/Debit card listed below.

By signing this form, you give us permission to debit your account for the amount on or after the indicated date. This is permission for a single and/or recurrent transaction(s) only, and does not provide authorization for any additional unrelated debits or credits to your account unless authorized by you.

_____.

Please complete the information below:

I _____ authorize **LORIA MEDICAL** to charge my credit/Debit card for a
(Full name)

One-time Deposit amount of **$**_____ on this date _____, and the recurrent Credit/Debit

_____**weekly** _____**Bi-weekly** payments in the amount of **$**_____ starting on this date _____.

The Total Payments to collect, which includes the Deposit and all recurring payments, will be **$**_____.

The Total Payment includes a **$500 Administrative fee**.

Billing Address _____ **Phone #**_____

City_____ **State**_____ **Zip**_____ **Email** _____

Account Type: _____Visa _____MasterCard _____AMEX _____Discover

Cardholder Name _____

Credit/Debit card Number _____

Expiration Date _____

CVV2 (3-digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE_____ Date _____

I authorized the above-named business to charge the credit/Debit card indicated in this Authorization form to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one-time and/or recurrent use only. I certify that I am an authorized user of this credit/Debit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicate in this form.

IF A DISPUTE ARISES REGARDING PAYMENT AND YOUR MEDICAL RECORD INFORMATION NEEDS TO BE DISCLOSED, YOU WAIVE YOUR RIGHTS TO CURRENT HIPPA LAWS GOVERNING PRIVACY OF YOUR MEDICAL RECORDS. SO, IF A DISPUTE WERE TO ARISE, YOU WILL AUTHORIZE LORIA MEDICAL TO PROVIDE THE NECESSARY INFORMATION EVEN IF IT INCLUDES YOUR MEDICAL RECORDS.