AMS
Alton MultiSpecialists
One Professional Drive, Suite 20
Alton IL 62002

PLEASE PRINT CLEARLY

Recurring Credit Card Charge Authorization

Cardholder's Name	Patient Name and Date of Birth*	E/I/A #

Billing Street Address	Cardholder's Telephone Number

City	State	Zip

Card Type (Check One)

Visa ☐ MasterCard ☐ Discover ☐

Credit Card Number	Expiration Date	Signature Code

If the recurring charge is for a specific recurring amount over a specific frequency, please indicate. Otherwise mark as N/A.

Recurring Amount	Frequency
	Weekly ( ) Monthly ( ) Quarterly ( )

This authorization will expire on the expiration date for this credit card, unless you want to terminate this authorization sooner. If you want to terminate this authorization sooner, provide a date for expiration.	Date this authorization expires

I authorize Alton MultiSpecialists, Ltd. to automatically charge my credit card account, shown above, for the legal payable amount allowed for healthcare services provided to the specific patient named above.

My right to use this service is subject to any limits established by my credit card issuer. It is my responsibility to update the credit card information that is used to pay for this service. I understand that I may notify Alton MultiSpecialists by written request at any time to terminate this authorization.

Alton MultiSpecialists reserves the right to charge this account without requiring the cardholder's signed authorization for each transaction. Also, Alton MultiSpecialists reserves the right to terminate this authorization agreement at any time.

Cardholder's signature (read statement above)	Today's date

*A separate authorization is required for each patient.