Payment Authorization Agreement

This Payment Authorization form will serve as the patient authorization and agreement for all providers within our Practice Management Group: Beyond Wellness LLC, Loudoun Family Chiropractic LLC, Dee Chiropractic PLLC, Natural Health Therapies LLC, Araya Holistic Pain Management LLC, Elite Performance Chiropractic and Wellness LLC and Core Health Chiropractic.

Patient(s) Name_____

Choose one of the following options:

❑ Option 1: Auto-Debit Virtual Terminal Authorization (your credit/debit card will be charged the next business day after your appointment)

I, [print name] _____, hereby authorize Beyond Wellness Practice Management Group LLC (BWPMG) and/or its contracted providers **to *initiate charges and corrections to previous charges to the card indicated below*.** These charges will reflect payment for performed services, supplements, health products, telephone consultations, missed appointment and late cancellation fees. If the card I have provided below is lost, stolen, or expires it is my responsibility to contact BWPMG and provide an alternate form of payment. I acknowledge that email receipts for all services and products will be sent to the email address I have provided. Authorization for this service is to remain in effect until I provide a written request of its withdrawal. BWPMG only accepts Visa® and MasterCard®. **Information provided below should be written legibly in print.**

Card Type: ❑ VISA ❑ MASTERCARD
❑FSA/HSA when are funds usually deposited into account? _____

Name on Card: _____

CC/Debit Card Number: _____

Card Expiration Date: _____/_____

(Card holder, if different from patient, must sign and date)

Card Holders relationship to Patient: _____

Card Holders Signature: _____ Date: _____

❑ Option 2: Pay Online

I will pay online (www.mybwdoc.com) for my services and products within **48 hours** after my appointment. **(You will receive a patient statement the next business day after your appointment by email with your account # and instructions for paying online. Please check your spam folder for emails from** billing@mybwdoc.com **)**

❑ Option 3: Pay by Phone

I will pay by Phone for my services and products within **48 hours** after my appointment by calling (703) 723 - 9355, press "4". (**You will receive a patient statement the next business day after your appointment by email. Please check your spam folder for emails from** billing@mybwdoc.com **)**

Patient (or Parent of) Signature: _____ Date**:** _____