peninsula doctor

Credit Card Authorization

If patient is the credit card holder, please ll out credit card information section below and leave the address section empty.

Credit Card Holder s Name: _____

Billing Address: _____

City:_____ State: _____ Zip Code:_____

Credit Card Type

_____ Visa

_____ Mastercard

_____ Amex

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

I hereby authorize the o ce of Peninsula Doctor to charge this credit card for practice membership fees.

Signature: _____

401 Burgess Drive, Suite D, Menlo Park, CA 94025
t: 650.800.3365 | f: 650.252.0043 | help@peninsuladoctor.com

peninsula doctor

ACH Authorization Form

If paying by ACH direct deposit, please fill out the information below.

Name on the Account: _____

Account Type:

_____ Checking

_____ Savings

Bank Account Number: _____

Bank Routing Number: _____

Bank Name: _____

Bank City, State: _____

I (Name) _____ authorize Peninsula Doctor to electronically debit my account and, if necessary, electronically credit my account to correct erroneous debits.

I understand that this authorization will remain in effect until I (we) notify Peninsula Doctor in writing, that I (we) wish to revoke this authorization. I understand that Peninsula Doctor requires a one month's notice in order to cancel this authorization.

If the payment is rejected due to non-sufficient Funds (NSF), I understand that Peninsula Doctor may attempt to process the transaction again within 10 days and I agree to an additional $30 NSF rejection fee charge for each attempt that is returned due to NSF, which will be initiated as a separate transaction from the authorized payment.

Signature: _____ Date: _____

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