100 North Main Street, Suite 150
Belmont, NC 28012
Phone: 704-461-8111 Fax: 980-819-4672

Credit/Debit Card/Checking Account Recurring Payment Authorization Form

I _____ authorize Landmark MD to charge my credit/debit card/checking account indicated below for the recurring monthly membership fees and/or ancillary charges deemed medically necessary for the individual(s) named here:

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

Account Type ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Checking Account

Cardholder Name _____

Billing Address _____ Phone _____

City, State, Zip _____

Account Number_____ Expiration Date _____

CVV (3-digit number on back of card/4 digit on front of Amex) _____ Zip Code _____

Routing Number _____ Account Number _____

Signature _____ Date _____

I authorize Landmark MD to charge the card/account indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business date. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Landmark MD in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next business date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this card/account and that I will not dispute scheduled payments with my credit card company/bank provided the transactions correspond to the terms indicated in this authorization form.