Eagle Run Chiropractic, PC
13808 W Maple Rd Ste 116
Omaha NE 68164
402-491-4087

Recurring Payment Authorization Form

Patient Name_____

Payment Frequency: Process once every month

Date of the month for transaction_____(ex. 15th)

Monthly transaction amount $_____(minimum of 1/3 of current statement balance)

☐ **Credit Card**

Name on card_____

Credit Card Type_____ Card Number_____

Expiration date____/_____ Security code_____

☐ **ACH from checking account**

Name on account_____

Bank routing number _____Account number _____

I hereby authorize EAGLE RUN CHIROPRACTIC PC to initiate debit or charge entries, as specified above.

I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge will be made to my bank account or credit card account on a periodic basis as specified above.

If my bank account or credit card information listed above changes for any reason, I will notify EAGLE RUN CHIROPRACTIC PC and a new authorization form will be completed by me promptly.

This authorization shall remain in effect until the total amount has been met or until EAGLE RUN CHIROPRACTIC PC has received written notification from me of its termination. Written notification of the cancellation must be received no later than the 5 business days prior to the next scheduled payment or the next scheduled payment will be automatically withdrawn from my account. For ACH Payment Authorizations I understand that I may also cancel this authorization by calling EAGLE RUN CHIROPRACTIC PC at 402-491-4087.

In the event of returned ACH or a declined charge, my account will be charged a service fee for each occurrence. I acknowledge receipt of a copy of this authorization form.

Signature_____Date_____