SUMMIT HEALTH GROUP
Primary Care • Integrative Medicine • Physical Therapy • Chiropractic

CREDIT CARD AUTHORIZATION

Membership 2024/2025 – Existing Patient

Date: _____

Payment Plan Choice: ____ 3 months ____ 6 months

Membership Type: _____ Individual ____ Child ____ Family

If Family Membership, please include Names of all Family Members:

_____

_____

	INDIVIDUAL	CHILD	FAMILY of 2 or more
Current Membership Rates	$350	$175	$600 + $50 per add'l child
Pay In Full	$350	$175	$600 + $50 per add'l child
3 Month Payment Term	$375	$188	$625 + $50 per add'l child
6 Month Payment Term	$400	$200	$650 + $50 per add'l child

Patient Name: _____ Patient Email:_____

I, _____, patient of Summit Health Group, authorize to have my credit card charged on a monthly basis as per my Membership Agreement.

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ /____ CVV ____ Zip Code _____

Please withdraw my monthly payment on the _____ day of each month until balance is paid in full.

I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form. Please email completed form back to **Billing@SummitHealth360.com**.

SIGNATURE _____ DATE _____