



Auto-pay Credit Card Authorization: _____

Re-occurring Authorization Agreement (Spinecare Associates use only)

I authorize SpineCare Associates, LLC, d/b/a Florida Spine Institute, hereinafter called COMPANY to initiate charges against my/our credit card listed below for payment as indicated below. If any of the below information changes, I will promptly complete a new authorization agreement within 10 business days.

Patient Name: _____

Patient Account Number: _____

Billing Address: _____

City: State Zip Code: _____

Daytime Telephone: _____

Card Type: Visa MasterCard American Express Discover
Name on Card: _____

Card Number: _____

Expiration Date: ____ / ____ (i.e. 05/2007)

CVV Code: _____

- **VISA, MasterCard, and Discover** - It is the last 3 digits after the credit card number on the back of the card in the signature area.
- **American Express** - The code is printed on the front of the card, above and to the right of the embossed card number.

I authorize SpineCare Associates, LLC d/b/a Florida Spine Institute, to charge:

One-time Amount of \$ _____ Reoccurring Monthly Amount of \$ _____

To begin on: ____ / ____ / ____
(MM / DD / YYYY)

This authority is to remain in full force and effect until the "Company" has received written notification from me within 30 days of its termination in such time and in such manner as to afford the "Company" a reasonable opportunity to act on it.

X _____
Signature of Authorized Cardholder

Date

Print First, Middle Initial and Last Name

Fax completed authorization to SpineCare Associates, LLC, Inc. at (727) 465-5791 or Mail to: Florida Spine Institute, Attention: Business Office, 2380 Drew Street, Suit #2, Clearwater, Florida 33765