THE VALLEY'S FERTILITY CENTER

Reproductive Institute of South Texas

110 E. Savannah Bldg B. Ste. 103 McAllen, TX 78503 956-687-2693 Fax 956-687-2829

PAYMENT AUTHORIZATION AGREEMENT

CHART #___________________NAME:____

ADDRESS:____

PHONE:________________________________MOBILE/EMAIL:_______________________________

PATIENT BALANCE DUE ON ACCOUNT: $___________________________

O CHECK PAYMENTS

I hereby authorize Dr. Esteban O. Brown to deposit the following checks on the dates noted below:

Check #____________ Amount: $_______________ Date :_____/_____/_____
Check #____________ Amount: $_______________ Date :_____/_____/_____
Check #____________ Amount: $_______________ Date :_____/_____/_____
Check #____________ Amount: $_______________ Date :_____/_____/_____

O CREDIT CARD RECURRING CHARGE AUTHORIZATION

I hereby authorize Dr. Esteban O. Brown to keep my signature on file and to charge my credit card for payments on the balance of charges for services that I am responsible for. I authorize the charge of the following amounts on the dates noted:

Amount: $_______________ Date of Charge :_____/_____/_____
Amount: $_______________ Date of Charge :_____/_____/_____
Amount: $_______________ Date of Charge :_____/_____/_____
Amount: $_______________ Date of Charge :_____/_____/_____

CREDIT CARD TO BE CHARGED:

____
CARDHOLDER NAME (as it appears on card) TELEPHONE NUMBER

____
ADDRESS (where card statements are mailed) CITY STATE ZIP

CREDIT CARD (Check One) **O**Visa **O**MasterCard **O**American Express **O**Discover

CARD NUMBER:____EXP. DATE:________/________

3 DIGIT V-CODE:______________ AMEX 4 DIGIT CODE ON FRONT OF CARD:____________

SIGNATURE OF CARDHOLDER:____DATE:________________

This authority is to remain in full force and effect until my account with Dr. Esteban O. Brown has been paid in full.

PATIENT SIGNATURE: ____DATE:________________

STAFF WITNESS SIGNATURE:_______________________________________DATE:________________