



CREDIT CARD ON FILE AGREEMENT

(This is a required document to receive treatment at EDTC, LLC)

Patient Name _____
Please Print First Last Middle Initial

I hereby authorize EDTC, LLC to keep my VISA/MC account information on file for payment and to initiate debit or charge entries on this account only as amounts are owed for services provided the patient named above.

Name on Account _____ Date of Birth: _____
Please Print First Last Middle Initial

Credit Card# _____ - _____ - _____ - _____ Exp. Date _____ CSV code _____

Card Type (check one) Visa Master Card Discover
Charges are not to exceed: \$ _____ for any single charge

This authorization expires: _____

Billing Address of Cardholder (Please Print)

Street _____ City _____ State _____ Zip _____

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 may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify EDTC, LLC. This authorization shall remain in effect until the end date as listed above or until EDTC, LLC has received written notification from me of its termination. In the event of returned ACH or a declined charge, my account will be charged a non-refundable service fee of \$35.00 for each occurrence.

Authorized Card Holder Signature Date

Please Return to: EDTC,
LLC
5203 Juan Tabo Blvd #2A
Albuquerque, NM 87111
(505) 266-6121