Credit Card Payment Authorization

❑ - **Recurring Charge** – You authorize regularly scheduled charges to your Credit Card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card Statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 5 days prior to the payment being collected.

I ________________________ authorize Southampton Healthcare, Inc to charge my Credit Card below for $________________ beginning on ____________ (Date) every Month.

❑ - **One (1) Time Charge** – You authorize the merchant below to make a one-time charge to your Credit Card listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I ________________________ authorize Southampton Healthcare, Inc to charge my Credit

Card indicated below for $_______________ on ____________ (Date).

Goods / Services Rendered: ____

Billing Details

Billing Address ____________________________ Phone # _______________________

City, State, Zip ____________________________ Email _________________________

Credit Card Information

❑ - Visa ❑ - MasterCard ❑ - AMEX ❑ - Discover

Cardholder's Name - _______________________

Credit Card Number - ____-____-____-____

Expiration Date - ____/____

Security Code (CVV) - ___

Individual's Signature ______________________________ Date ____________

<u>Mail Return Address</u>
Southampton Healthcare
Attn: Billing Dept.
2340 Hampton Ave.
Saint Louis, MO 63139

or

<u>Fax</u>
(314) 647-4172