EZ-Pay Signature-On-File Authorization

I, _____, hereby authorize **Carter Chiropractic Center, LLC dba Carter Chiropractic & Laser Pain Solutions** to initiate payments from my credit or bank account with the financial institution identified by me on this form for payment of services and/or products provided by **Carter Chiropractic & Laser Pain Solutions**, not to exceed $ _____ per transaction.

_____ (initial) I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Carter Chiropractic & Laser Pain Solutions** in writing of any changes in my account information or termination of this authorization at least 5 days prior to any further charges to my credit card or bank account. I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. Notice to cancel can be given by either mailing to: **2510 Wade Hampton Blvd Ste B1 Greenville SC 29615,** emailed to: **frontdesk@carterchiropractic.com** or faxing to: **864-268-8198.**

Signature: _____ Date: _____

CREDIT CARD *(last 4 digits)* ____ ____ ____ ____ (Circle One) VI, MC, AM, DI

Card Holder's Printed Name: _____

Signature: _____ Date: _____

ACH BANK ACCOUNT *(last 4 digits)* ____ ____ ____ ____

Bank Name: _____

Bank Account Holder's Name: _____

If ACH Transactions are rejected for Non Sufficient Funds (NSF) I understand that **Carter Chiropractic & Laser Pain Solutions** may at its discretion attempt to process the charge again within 30 days, and agree to any additional **$25.00** charges for each attempt returned NSF which will be initiated as a separate transaction.

Signature: _____ Date: _____

Billing Address Associated with Credit Card or Bank Account

Billing Address:_____ Phone: _____

City, State, Zip: _____