SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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## PAYMENT OPTIONS

For accounts payable, SXM can accept on-line payments, cash, debit card, credit card or any combination. For check payments and credit card payments SxM will need on file a copy of a voided check or credit card.

**Automatic Payment Agreement for Credit Card Account**: Yes, I would like to sign up for monthly revolving automatic check withdrawal for any and all incurred fees for services retender at Symptom Medicine. Payments will automatically be taken from my checking account on the 3oth of each month for any outstanding balance. I _____ hereby authorize Chante S Buntin MD, Inc. and Symptom Medicine to charge the indicated credit card as payment for the all incurred fees for services rendered. I understand denied credit cards will incur a $30.00 fee per event and it will e charged to my Clinic account. This authority remains in effect until Symptom Medicine or Chante S. Buntin, MD Inc has received written notification from me of termination to allow reasonable opportunity to act on it or until Symptom Medicine has sent me written notice of termination of this agreement. I guarantee and warrant that I am the credit card account holder provided and I am legally authorized to enter into this recurring billing agreement.

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| Name on Credit Card | | address | City State Zip |
| Credit Type. | Credit Card No. | Security Code | Exp. Date |
| Date | Signature | Printed name | |

**Automatic Payment Agreement from Checking Account**: Yes, I would like to sign up for monthly revolving automatic check withdrawal for any and all incurred fees for services retender at Symptom Medicine. Payments will automatically be taken from my checking account on the 3oth of each month for any outstanding balance. I _____ hereby authorize Chante S Buntin MD, Inc. and Symptom Medicine to instruct my financial institution to make my monthly bill payments for the all incurred fees for services rendered. I understand insufficient funds for checks will incur a $30.00 fee per event and it will e charged to my Clinic account. This authority remains in effect until Symptom Medicine, Chante S. Buntin, MD Inc has received written notification from me of termination to allow reasonable opportunity to act on it or until Symptom Medicine has sent me written notice of termination of this agreement. I guarantee and warrant that I am the legal check account holder provided and I am legally authorized to enter into this recurring billing agreement.

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| **ATTACH COPY OF VOIDED CHECK HERE. YOUR VOIDED CHECK MUST BE INCLUDED TI PROCESS YOUR EFT REQUEST** | | | |
| Name on Checks | | address | City State Zip |
| Name of Bank | | Check Rounding No. | Check Account No. |
| Bank and Address | | | |
| Copy of check | Signature | | Printed Name |