Elevate Health Card Authorization Form

I, _____, give permission to Dahra Perkins, MD PC dba Elevate Health, to charge
Buyer name

my card monthly for my EH membership and/or approved purchases. My card details will be stored in my profile and will only be used for approved purchases.

Amount authorized

Cardholder email

For Office use only

Card information

Card type

- [ ] MasterCard
- [ ] Discover
- [ ] VISA
- [ ] AMEX
- [ ] Other

Cardholder (Name on card)

Card number

Expiration date
(MM/YYYY)

ZIP code
(From credit card billing address)

Customer signature

Date

Elevate Health will use the card information on account to continue with the 2025 rate increase as agreed to in the signed office policy.
I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Elevate Health in writing of any changes in my account information or termination of this authorization at least 30 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card