Priority Care Boston

Credit Card Authorization

Priority Care Boston
Membership-Based Primary Care Practice
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Boston, MA 02114

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Credit Card Authorization Form

Patient Name: _____

Date of Birth: _____

Primary Phone Number: _____

Email Address: _____

Authorization Agreement

I, the undersigned, hereby authorize **Priority Care Boston** to charge the credit card listed below for membership fees that I elect to receive as a patient. **Start Date of Membership:** 5/1/2025

Cardholder Information

Name on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Credit Card Details

Check Type: Visa____ MasterCard____ American Express____ Discover____

Card Number: _____ _____ _____ _____ **Expiration Date (MM/YY): _____ / _____**

CVV (3 or 4 digits): _____

Authorization Terms

By signing below:

- I authorize **Priority Care Boston** to charge my card for the agreed upon membership fees and any related services as indicated.
- I understand that this authorization will remain in effect until I cancel it in writing, and that cancellations must be made **at least 30 days in advance** of the next billing cycle.
- I understand that declined or invalid cards may result in a suspension of services until payment is resolved.
- I agree to notify Priority Care Boston of any changes in credit card information or if my card is lost or stolen.
- I acknowledge that this form is kept on file securely and will be used for future transactions as described.

Cardholder Signature

Signature: _____ Date: _____

Office Use Only

Patient ID #: _____

Processed by: _____

Date Received: _____