ARIS Solutions

Financial & Payroll Services for the Nonprofit Sector

Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the patient share payment each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. It will be adjusted to match your monthly due amount as necessary. You agree that no prior-notification will be provided.

I _____ authorize ARIS Solutions, Inc. to charge my Credit Card for the monthly payment of Patient Share and a 3% surcharge on the last day of each month.
(Cardholder's Name)

Patient Share Participant_____ **Consumer ID #** _____

Credit Card Billing Information

Billing Address _____ **Phone #**_____

City, State, Zip _____ **Email** _____

Credit Card Details

☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Cardholder's Name _____ **Credit Card #** _____
(Printed exactly as it appears on Credit Card)

CVV _____ **Expiration Date** _____ /_____ **Zip Code** _____

I understand this authorization for recurring payments will remain in effect until I cancel it in writing. I agree to notify ARIS Solutions, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I understand that the payments may be executed on the next business day, if the above noted payment dates fall on a weekend or holiday. I acknowledge the origination of Credit Card 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 and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

Signature _____ **Date** _____
(Cardholder's Signature)

Dedicated to your Peace of Mind
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