Automatic Draft Agreement

I choose to pay my balance **IN FULL** at each visit. The card listed below will be kept on file and charged for the balance due at each visit. This must be on file for any patient choosing telehealth nutrition services.

Card Number: _____ Exp: _____/_____ Code: _____

Name on Card: _____

By signing this form, I hereby authorize Ballard Family Chiropractic to keep the card listed above on file and to charge it for the full balance due at each visit. **I understand that the credit card processor charges a 3.75% surcharge on card payments, and that this surcharge will be added to each charge made to my card. Payments made by cash or check are not subject to this surcharge.**

This authorization shall remain in force until I cancel the auto draft service with a written notice. I understand that cancellation does not negate my responsibility to pay for the services or products I have been provided.

Signature: _____ Date: _____

14225 E. Rickeman (1600th Ave)
Effingham, IL 62401
www.ballardfamilychiro.com or
www.facebook.com/ballardfamilychiro
P: (217)347-5010