Dietitians ABQ
A subsidiary of Eating Disorders Treatment Center, LLC

# CREDIT CARD ON FILE AGREEMENT

Patient Name _____
Please Print First Last Middle Initial

I hereby authorize Dietitians ABQ, LLC to keep my VISA/MC account information on file for payment and to initiate debit or charge entries on this account only as amounts are owed for services provided the patient named above.

Name on Account _____ Date of Birth _____
Please Print First Last Middle Initial

Credit Card# _ _ _ _ -_ _ _ _ -_ _ _ _ -_ _ _ _ Exp. Date_____CSV code _____

Card Type (check one) ☐ Visa ☐Master Card ☐Discover

Charges are not to exceed: $_____for any single charge

This authorization expires: _____

Billing Address of Cardholder (Please Print)

_____
Street City State Zip

I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify DABQ, LLC. This authorization shall remain in effect until the end date as listed above or until DABQ, LLC has received written notification from me of its termination. In the event of returned ACH or a declined charge, my account will be charged a non-refundable service fee of $35.00 for each occurrence.

_____ _____
Authorized Card Holder Signature Date

Please Return to:

Dietitians ABQ
5203 Juan Tabo Blvd #2E
Albuquerque, NM 87111
(505) 266-6121