



RECURRING PAYMENT AUTHORIZATION FORM

- TMC PARKING TMC NEWS
 HORNBERGER CONF. CTR. FAVROT TOWERS

PLEASE CHECK APPROPRIATE BOX(ES):

- RECURRING CREDIT CARD AUTHORIZATION
 AUTOMATIC DIRECT DEBIT AUTHORIZATION

Date
Contract #
Institution

First Name	M.I.	Last Name
Mailing Address		
City	State	Zip Code

RECURRING CREDIT CARD AUTHORIZATION

- VISA MasterCard
 AMEX Discover

Charge Account Number:

Card Expiration Date:

Initial Monthly Amount Due: \$.

I/We hereby authorize Texas Medical Center to charge this credit card on a monthly basis for the amount due under my/our contact with Texas Medical Center as indicated above, as such amount due under such contract may change from time to time. If the monthly amount initially charged under such contract changes, Texas Medical Center will provide written notification of the new amount prior to the first scheduled transaction date for that new amount. My/our credit card will be charged on or about the first business day of each month for the amount due. If necessary, Texas Medical Center may initiate credit adjustments for any charges made in error.

Signature _____ Date _____

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEBITS (ACH DEBITS)

I/We hereby authorize Texas Medical Center to initiate debit entries on a monthly basis to my (our) Checking Savings Account (select one) indicated below for the monthly amount of \$_____ due under my/our contract with Texas Medical Center as indicated above, as such amount due under my contract may change from time to time. If the monthly amount initially charged under such contract changes, Texas Medical Center will provide written notification of the new amount prior to the first scheduled transaction date for that new amount. My account will be debited on or about the first day of each month for the amount due. Texas Medical Center will add a returned payment fee for each payment a financial institution returns to Texas Medical Center. If necessary, Texas Medical Center may initiate credit entries to adjust for any entries made in error. To ensure correct coding information, please attach voided deposit slip or check.

Bank Name	City	State	Zip Code
Transit/ABA No.		Account Number	

Signature _____ Date _____

YOUR BILLING RIGHTS

This Recurring Payment Authorization is to remain in full force and effect until Texas Medical Center has received written notification from me (or either of us) of termination of this service in such time and in such manner as to afford Texas Medical Center and other applicable third parties a reasonable opportunity to act upon it. Written notice may be provided either to the address below or via email to customerrelations@texmedctr.tmc.edu.

If you think your monthly statement is incorrect or if you need more information concerning a transaction on your statement, please send a certified letter to the address listed below:

**TEXAS MEDICAL CENTER
 BILLING SERVICES
 2151 WEST HOLCOMBE BLVD.
 HOUSTON, TEXAS 77030-3303**

Please provide your name, contract number, telephone number and a brief explanation of the problem. We will make any necessary adjustments to your account within 30 days. After 60 days all charges will be assumed correct. You may telephone us at (713) 791-6161 or fax us at (713) 791-6162 but doing so will not reserve your rights.

PLEASE READ CAREFULLY AND INITIAL BELOW

I/We have read and understand the policy on cancellation and agree to all terms by initialing below.

Customer's Initials _____ Date _____