Texas Medical Center
RECURRING PAYMENT AUTHORIZATION FORM

PLEASE CHECK APPROPRIATE BOXES AND COMPLETE INFORMATION BELOW

☐ **CHARGE CREDIT CARD** ☐ **DEBIT FROM CHECKING ACCOUNT**

Name	☐ Individual ☐ Organization
Mailing Address	
City/State/Zip Code	**Last 4 Digits of Credit Card Number or Checking Account Number**
Customer Number	**Parking Contract Holders Name:**

I hereby authorize Texas Medical Center to charge my credit card number listed below or to initiate debit entries to my checking account indicated below on a monthly basis for the amount due under my contract 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 notification of the new amount prior to the first scheduled transaction date for that new amount. My credit card or checking account 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. For automatic direct debit payments, Texas Medical Center will add a returned payment fee for each payment a financial institution returns to Texas Medical Center.

This Recurring Payment Authorization is to remain in full force and effect until Texas Medical Center has received written notification from me 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@texasmedicalcenter.org.

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
2450 HOLCOMBE BLVD STE 1
HOUSTON, TEXAS 77021-2040

Please provide your name, Customer 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) 791-6143 but doing so will not reserve your rights.

I have read and understand the cancellation policy and applicable fees for returned payments and agree to all terms by signing below.

Signature _____ Date _____

Please complete the payment information below

☐ CHARGE CREDIT CARD ☐VISA ☐MASTERCARD ☐AMEX ☐DISCOVER

Credit Card Number (enter full credit card number)	**Expiration Month/Year**

☐ AUTOMATIC DEBIT (ACH DEBIT) FROM CHECKING ACCOUNT

TO ENSURE CORRECT CODING INFORMATION, PLEASE ATTACH VOIDED CHECK.

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

CONTAINS CONFIDENTIAL INFORMATION

Revised December 2013