relyMD
24/7 Online Urgent Care
Staffed by Wake Emergency Physicians PA

Electronic Payment Authorization Form

Please type or print all entries.

$ _____ Monthly Service Fee **Service Start Date : _____**

Business Name: **Billing Phone Number:**

Address: **Email Address for Billing:**

City: **State:** **Zip:**

Step 1: Choose the action you wish us to take.

☐ **START First Time Request** (Complete Steps 2, 3, 4, & 5 Below)

☐ **CHANGE Request to Existing** (Complete Steps 2 & 5 Only)

☐ **STOP Request to Existing** (Complete Steps 5 Only)

Step 2: Select payment option to start or change and provide information requested.

☐ **Electronic Funds Transfer (EFT):** Please start or change the automatic withdrawal of my monthly membership fees payable to RelyMD by means of EFT from my financial institution. **Please provide a VOIDED check.**

Please check one: ☐ Checking ☐ Savings _____ Name of Financial Institution

_____ Name of Account Holder _____ 9 Digit Bank or ABA Routing Number _____ Account Number

☐ **Recurring Credit Card (RCC):** Please start or change the automatic withdrawal of my monthly membership fees payable to RelyMD by means of RCC from my financial institution.

Please check one: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express *(charges will appear as "RelyMD" on your credit card statement)*

_____ Name of Card Holder _____-_____-_____-_____ 16 Digit Credit Card Number _____/_____ Expiration Date (MM/YYYY) CVC

☐ **Invoice Directly to billing contact above.** All payments are due net 30 days.

Step 3: Select frequency. *All payments will be processed on or about the 15th of the month.*

☐ **Monthly**
☐ **Quarterly**

Step 4: Enrollment fee due with the submission of your START request.

I agree to pay the one-time enrollment fee of $_____ via the above payment method.

Step 5: Authorize this request with your signature and return by mail or fax.

My signature authorizes RelyMD to START, CHANGE, or STOP my automated payments as indicated in STEP 1. If I do not have an existing account with RelyMD, my signature authorizes RelyMD to charge a one-time enrollment fee as indicated in STEP 4. I understand that monthly fees will be withdrawn as specified in STEP 3. This authorization will remain in force unless canceled by me, RelyMD, or my financial institution.

Authorized Signature (*Required*): _____ **Date:** _____

Mail this form to: RelyMD Finance
210 Towne Village Dr.
Cary, NC 27513

or email form to: finance@relymd.com