



Payment Authorization Form

For LBS Clients

I hereby authorize LARSEN BILLING SERVICE, LLC to set up this one-time payment or recurring payments as specified below and, if necessary, to initiate adjustments for any transactions credited/debited in error. This authorization will remain in effect for the duration of the term of the Exclusive Billing Management Agreement between myself and LARSEN BILLING SERVICE, LLC. I agree that I will indemnify and hold LARSEN BILLING SERVICE, LLC harmless against any liability pursuant to this authorization. I understand that the signature on this form will serve as authorized signature with regards to this credit card or bank account transaction. (Note: Larsen Billing Service, LLC will cover merchant account fees.)

Type: Bank withdrawal (complete boxes 1 & 2) Credit card payment (complete boxes 1 & 3)

CLIENT INFORMATION (This information must match the records at your bank or credit card company.)

Name (Last, First, MI) _____ Date _____

Address _____ City _____ State ____ Zip _____

Home Phone(____) _____ Alternate Phone(____) _____ Email _____

Midwife's Name _____ Service Type Code _____

Service Type Codes: 1=Midwife paying her account, 2=Midwife paying initial set-up fee, 3=Midwife paying Client Billing set-up fee (\$39), 6=Mom making a pay plan payment, 7=Mom paying for a verification of benefits (\$15), 8=Mom paying Patient Reimbursement Program fee (\$49), 9=Other - If other -

Please add brief description: _____

BANK INFORMATION

Bank Name: _____ Type: Checking Savings

Account #: _____ Routing #: _____

Payment Frequency:

One-time charge of \$ _____ (will be processed immediately)

Automatic withdrawals for the balance due on monthly invoice, to be deducted on the _____ day of the month; start date: _____

CREDIT CARD INFORMATION

Type: Visa MasterCard Discover Credit Card #: _____

Expiration Date: _____ Three-digit CV Code (from back of card): _____

Payment Frequency:

One-time charge of \$ _____ (will be processed immediately)

Automatic debits for the balance due on monthly invoice, to be charged on the _____ day of the month; start date: _____

Authorization Signature: _____ Date _____

Submit form to Larsen Billing Service, LLC via this fax line: (888) 317-4885.

Your information will be kept strictly confidential. Questions? Email payments@larsenbilling.com.