

Auto-Payments Authorization Form

To give auto-pay authorization complete, sign this form and mail it to our Patient Billing Office: P.O. Box 525 Lewis Center OH 43035 (recommended to use the provided secure envelope with this billing statement). You may also email this form to billing@arbilling.com. Attention or Subject to: HDH Patient Billing Department. If you have both Facility and Physician charges, **TAKE NOTE ONLY YOUR FACILITY CHARGES CAN BE SETUP ON A PAYMENT PLAN.**

Here's How Auto-Pay Works: You authorize regularly scheduled auto-charges to your Checking, Savings, Credit or Debit card account. You will be charged the amount indicated below each billing period until the balance is paid in full, or the stated number of payments has been reached. It is important to review payment requirements before submitting this form. If signing up for paperless email. Please provide the email address you wish to use below (must be a private email, non-work or school). Paperless enrollment form is also available online at www.arbilling.com/hdh.

REQUIREMENTS: Enter the number of payments, payment amount and payment date below. The minimum monthly payment is your Total Facility Balance due divided by 24 equal payments, or \$25/m, whichever amount is greater. Payment Plans that do not fall within these rules will be rejected and a representative will contact you for assistance. Take note the Amount Due Now on your billing statement may include both Facility and Physician charges.

Please Select A Payment Option & Fill Out The Information Below: **Monthly** **One-time payment**

I _____ authorize Highland District Hospital's Patient billing department to charge
(Print Full Legal Name)
my payment account _____ times indicated below for _____ on _____ each month starting in _____, for
(enter 1-24) (insert \$) (insert day 1-28) (enter month, current or next)
payment on account number _____
(enter the account # at the top of your billing statement)

Enroll in Paperless Billing, mark phone or email below and enter your information. DATA rates may apply for text. Please use a private email address, that can only be accessed by you or someone authorized.

Billing Address: _____

Phone: _____

City, State, Zip: _____

Email: _____

Checking Savings Credit/Debit*

Name on Acct _____
(print)

Bank or Card # _____

If Bank Enter Routing # _____

If CC/DC Enter CSV # _____

If CC/DC Enter EXP Date _____

**A \$5.00 processing fee will be including for use of credit or debit card, by signing this form you agree to these terms.*

If you have multiple self-pay facility charges with Highland District Hospital, and want to combine them in to one auto-payment plan, please list those visits below. See payment plan requirements above. If you already have a payment plan established please call the billing office to combine your additional balances: 877-879-6613.

SIGNATURE _____

Date _____

Please read carefully before signing:

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the billing department in writing of any changes in my payment account information or termination of this authorization at least 15 days prior to the next billing due date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand the billing department may at its discretion attempt to process the charge again within 30 days, and I agree to an additional \$30.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank or credit card account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.