PATIENT NAME: _____ **PATIENT #** _____

Credit Card Debit Request

Request and Authority to debit the credit card below to pay
Dr Antoniou (314011)

Request and Authority to debit	**Surname (or company name)** _____ **Given names (or ACN/ARBN)** _____ ("you") request and authorise ***Dr Antoniou (314011)*** to debit the credit card identified below, subject to the terms and conditions of the Credit Card Debit Request Service Agreement.
Indicate ☒ card type	**Visa Card** ☐ **Bankcard** ☐ **MasterCard** ☐
Insert details of credit card to be debited	**Name of cardholder** _____ **Card Nbr** |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___| **Expiry Date** |___|___|-|___|___|
Acknowledgment	By signing this Credit Card Debit Request you acknowledge having read and understood the terms and conditions governing the debit arrangements between you and ***Dr Antoniou (314011)*** as set out in this Request and in your Credit Card Debit Request Service Agreement.
Payment Details **(Circle option)**	☐ The maximum amount to be debited at any one time is: $ |___|___|___| - |___|___| _____ (amount in words) ☐ The first debit may be made in ___ / ___ (Month/Year) at monthly intervals on the 1st week / 2nd week / 3rd week / 4th week of the month
Insert your signature and address	**Signature** _____ (If signing for a company, sign and print full name and capacity for signing eg. director) **Address** _____ _____ **Email address (for receipts/statements):** _____ **Date** ___ / ___ / ___

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