Thank you for your continued Membership. With a signature below Texas Professional Healthcare Alliance is authorized to debit the designated banking or credit account $336 once a year for your annual dues upon the anniversary of your membership to the IPA.

Provider Full Name: _____

Email for Payment Receipt: _____

CREDIT CARD PURCHASE AUTHORIZATION

Cardholders Name (as it appears on credit card)_____

Full Provider Name from Invoice: _____

Zip Code for Credit Card billing address: _____

Credit Card Number: _____

Expiration Date: _____

ACH TRANSFER AUTHORIZATION

Bank Name: _____

Address: _____

City: _____ State: _____ Zip: _____

ACH Routing Number: _____

Account Number: _____

_____ Checking _____ Savings _____ Modified Lock Box ___Other: _____

AUTHORIZATION

Name: _____

Signature:_____ Date: _____

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