Credit Card Information

Name on Card: _____
Billing Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone Number: _____

Credit Card Type (check one):
☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number: ____ ____ ____ ____ – ____ ____ ____ ____ – ____ ____ ____ ____ – ____ ____ ____ ____
Expiration Date: _____ / _____
CVV (3 or 4 digits): _____

Authorization to Store Credit Card Information

- This stored information will be used solely to process charges related to Remote Patient Monitoring (RPM) devices not returned or returned in damaged condition.
- I may revoke this authorization at any time by:
    - Submitting written notice to Home Physicians Group
    - Returning all RPM equipment in working condition to Home Physicians Group

Authorization and Acknowledgment

By signing below, I authorize Home Physicians Group to charge my credit card only if I fail to return RPM equipment or return it damaged. I understand that:

- I am not being charged for participation in the RPM program.
- I will be notified prior to any charge being made.
- Replacement costs may include tablets, monitoring devices, and accessories, as outlined in the patient agreement.

Data Security Acknowledgment

Home Physicians Group has implemented technical, administrative, and physical safeguards to protect your personal and financial information from unauthorized access, disclosure, or misuse. While no system can offer 100% protection, reasonable and appropriate measures are in place to secure your data.

Consent and Signature

By signing below, I acknowledge that I have read and understood the information above and agree to the terms of this authorization.

Patient Name: _____
Date of Birth: _____ / _____ / _____
Signature: _____
Date: _____ / _____ / _____

Please return competed form to securepaymentforms@hpg.health