



Orange City Area
Health System

INTEGRITY • INNOVATION • INSPIRATION

1000 Lincoln Circle SE
Orange City, IA 51041
Phone: 712.737.5200
Fax: 712.737.5354

AUTHORIZATION FORM FOR AUTOMATIC PAYMENTS

Account number: _____

Name on Account: _____

Phone number: _____

Amount of payment: _____

Monthly: _____ Bi-Weekly: _____ Weekly: _____ (select one)

Date of first payment: _____

Total number of payments: _____

Visa: MasterCard: Discover: AmEx:

Name on card: _____

Last 4 digits of card: _____ Expiration: _____

Billing address: _____

I authorize Orange City Area Health System to process a recurring payment to my credit card according to the above information. By signing below, I confirm that I am an authorized signatory on the credit/debit account.

Signature (as it appears on the credit card): _____

Date: _____

Please complete this form and email to: OCBusinessOffice@ochealthsystem.org or mail to the above address for OCHAS. Once we have received the completed form, you will receive a call to confirm and begin the automatic payment process.