



**NATIONAL TRT CLINICS**  
 Company Number: (615) 205-7756  
 695 President Place, suite 200, Smyrna  
 TN 37167  
 Email: help@nationaltrtclinics.com

# Recurring Payment Authorization Form

## National TRT Clinics

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

### Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

### Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

### Please complete the information below:

Mark your selection below by placing a check mark in one of both spaces

I authorize National TRT Clinics to charge my account indicated below for:

: 50\$ one time payment for low testosterone testing

: 185\$ monthly payment on the \_\_\_\_ day of the month for TRT medical care

\*185\$/Month all inclusive payment includes treatment with either a testosterone medication OR HCG medication, not both. A separate charge is required for the addition of one of those medications. 185\$ per month charge will cover cost of any associated labs and consultations with medical provider. Any supplies needed for administration of the medication are covered and no charge.

Billing Address

\_\_\_\_\_  
 \_\_\_\_\_

Phone#

\_\_\_\_\_  
 \_\_\_\_\_

City, State, Zip

\_\_\_\_\_

Email

\_\_\_\_\_

### Checking/ Savings Account

Checking       Savings

Name on Acct

\_\_\_\_\_

Bank Name

\_\_\_\_\_

Account Number

\_\_\_\_\_

Bank Routing #

\_\_\_\_\_

### Account

Visa       MasterCard       Amex       Discover

Cardholder Name

\_\_\_\_\_

Account Number

\_\_\_\_\_

Exp. Date

\_\_\_\_\_

CWV (3 digit number on back of card)

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify National TRT Clinics (business name) in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing 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 that National TRT Clinics (business name) may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$10 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 credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.