Venture Medical Weight Management

KAISER PERMANENTE®

Payment Card Authorization Notice

This notification confirms your authorization provided on _____ (Date) to store your payment card information and to electronically charge your payment card account for any charges associated with your enrollment in the **Medical Weight Management** at Kaiser Permanente.

Cardholder name:	
Patient name:	
Address:	
Venture Account Number: (office use only)	
Billing ID #: (office use only	
Services provided:	**Monthly fees and meal replacement charges**.
Start date of payment: (0ffce use only)	
End date of payment (1 calendar year from start date): (office use only)	

This authorization will remain in full force and effect until you notify us by phone three (3) business days, or more, before first payment is electronically charged to your payment card.

Should you have any questions or choose to cancel this authorization, feel free to contact us during the hours of **8:30am-5:30pm**, **Monday through Thursday** in **Medical Weight Management**, at **(650) 299-4999**

PAYMENT CARD AUTHORIZATION

I, _____, understand and agree to the terms and conditions of this Kaiser Permanente Payment Card Authorization Notice. If this authorization does not cover the patient's full financial liability, then the patient's guarantor will receive a bill for additional charges based on the specifics of the patient's health coverage, benefits and the actual services the patient receives. **As long as I'm enrolled in the program, I allow Kaiser Permanente to automatically renew this authorization until I cancel or dis-enroll from the program.**

X_____ Date: _____

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For Venture Department Use Only:

Date Cancellation Requested: _____ Registration Staff: _____