Easy Pay Consent Form

I understand and agree to authorize **Practice Management Institute® (PMI)** to maintain my credit, debit, or check card on file for the balance charges to be paid according to the following payment agreement:

Program/Course Title(s): _____

Program/Invoice #: _____

Program/Course Fee: $ _____
Discounts (if applicable): _____
Taxes (if applicable): _____
S/H Fee (if applicable): _____
TOTAL: $ _____

I agree to pay the above program/course purchase fees. I understand that I must pay 50% of the total fee at prior to beginning the course and the final payment at least ten (10) business days prior to the course conclusion. I am aware that I can make a total of three (3) consecutive payments within a 90-day period; furthermore, I give my consent to PMI to charge/debit my credit card, debit or check card on said dates until the balance is paid in FULL as follows:

1st payment of $ _____ (50% Total Fee) will be made on _____ (Date)
2nd payment of $ _____ (25% Total Fee) will be made on _____(Date)
3rd payment of $ _____ _ (25% Total Fee) will be made on _____(Date)

Please have funds available as agreed. You will be held liable for returned payment fees incurred and processing time.

I understand that this form is valid for one year unless I cancel the authorization through written notice and make other payment arrangements for full balance payment. I understand I am liable and will be held responsible for the FULL payment of my purchase and all means of collection will be used. By signing this form, I agree to the Terms and Conditions underlined herein.

_____ #_____
Course Registrant Name PMI Invoice

X_____ **X**_____
Signature Date

NOTE: All pages of this form must be completed in full and signed prior to Program/Course commencing. Payment dates and arrangements must be first approved by the PMI Accounting Department. All applicable cancellation policies will be enforced during the term of this agreement.

PRACTICE® MANAGEMENT INSTITUTE

Billing Information

Name: _____

Address: _____

City: _____ State _____ Zip code: _____

Phone: (___) _____ Fax: (___) _____

Cell Phone: _____ Email: _____

Shipping Information

Employer/Organization Name: _____
(if applicable)

ATTN: _____

Address: _____

City/State: _____ Zip code: _____

Phone: (___) _____ Fax: (___) _____

Direct line or extension: (___) _____ Email: _____

Credit Card Information

Use for Payment date(s): _____

Card Type: ❑ VISA ❑ MasterCard ❑ American Express

Card Number: _____ Security Code: _____

Expiration date: _____ Cardholder: _____

Cardholder Billing Address: _____ Apt/ Ste/PO Box _____

_____

City: _____ State _____ Zip code _____

Cardholder Contact Number (___) _____ Email: _____

Please email the completed form to:

Practice Management Institute Accounting Department
Email: accounting@pmiMD.com
Fax: 210.691.8972
Inquiries: 800-259-5562

PRACTICE® MANAGEMENT INSTITUTE

Do not write below this line

PMI OFFICE USE ONLY

PAYMENT	AMOUNT	DATE CHARGED	REFERENCE #	AUTHORIZATION CODE
1				
2				
3				

Approved by: