



Easy Pay Consent Form

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

Program/Course Name: Certified Medical Coder

Program #: 26380-0921

Course Fee:	\$ <u>1375.00</u>
Discounts (if applicable):	- (<u> </u>)
Code <u> </u>	Subtotal <u> </u>
S/H Fee (if applicable):	+ <u> </u>
TOTAL FEE:	\$ <u> </u>

I understand that the 1st payment is required to gain access to the class sessions and materials, and that payment in full is required before I can request a certification examination.

I agree to pay the TOTAL FEE noted above in up to six (6) installments with the final payment due by November 16, 2026. I give my consent to Practice Management Institute to charge my credit card(s) and/or debit card(s) for the amount specified on the following dates until the balance is paid in FULL:

1st payment of \$ will be made on (Date)
 2nd payment of \$ will be made on (Date)
 3rd payment of \$ will be made on (Date)
 4th payment of \$ will be made on (Date)
 5th payment of \$ will be made on (Date)
 6th payment of \$ 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 to pay the balance in full. I understand that I am liable and will be held responsible for the FULL payment of my purchase and all means of collection will be used. My signature indicates my agreement with these Terms and Conditions.

Course Registrant Name

PMI Invoice (if applicable)

Signature

Date

NOTE: All pages of this form must be completed in full and signed prior to 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.

Billing Information

Billing Information

Name: _____	
Address: _____	
City: _____	
State / Province: _____	Postal code: _____
Country: _____	
Phone: () _____	Fax: () _____
Cell Phone: _____	Email: _____

Shipping Information

Employer/Organization Name: _____ <i>(if applicable)</i>	
ATTN: _____	
Address: _____	
City: _____	
State / Province _____	Postal code: _____
Country _____	
Phone: () _____	Fax: () _____
Direct line or extension: () _____	Email: _____

Do not write below this line

<i>PMI OFFICE USE ONLY</i>				
PAYMENT	AMOUNT	DATE CHARGED	REFERENCE #	AUTHORIZATION CODE
1				
2				
3				
4				
5				
6				

Approved by: _____ Date: _____

Credit Card Information (1st card)
Use for Payment date(s): _____

Card Type:	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express
Card Number:	_____		Security Code: _____
Expiration date:	_____	Cardholder:	_____
Cardholder Billing Address:	_____		Apt/ Ste/PO Box _____
City:	_____	State _____	Zip code _____
Cardholder Contact Number ()	_____	Email:	_____

Credit Card Information (2nd card)
Use for Payment date(s): _____

Card Type:	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express
Card Number:	_____		Security Code: _____
Expiration date:	_____	Cardholder:	_____
Cardholder Billing Address:	_____		Apt/ PO Box# _____
City	_____	State _____	Zip code _____
Cardholder Contact Number ()	_____	Email:	_____

Please fax or scan/email the completed form to:

Practice Management Institute, Accounting Department

 Email: accounting@pmiMD.com

Fax: 210.691.8972

Inquiries: 800-259-5562