

## 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 Name: \_\_\_\_\_

Program #: \_\_\_\_\_

Program/Course Fee: \$ \_\_\_\_\_  
Discounts (if applicable): \_\_\_\_\_  
Taxes (if applicable): \_\_\_\_\_  
S/H Fee (if applicable): \_\_\_\_\_  
TOTAL FEE: \$ \_\_\_\_\_

I agree to pay the above program/course purchase fees. I understand that I must pay 50% of the course fee at least ten (10) business days before the course begins and the final payment at least ten (10) business days prior to the course conclusion. I am aware that I will be allowed to 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:

1<sup>st</sup> payment of \$ \_\_\_\_\_ (50% Total Fee) will be made on \_\_\_\_\_ (Date)  
2<sup>nd</sup> payment of \$ \_\_\_\_\_ (25% Total Fee) will be made on \_\_\_\_\_ (Date)  
3<sup>rd</sup> 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 to have the balance paid 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. By signing this form I agree to the Terms and Conditions underlined herein.

\_\_\_\_\_  
Course Registrant Name

# \_\_\_\_\_  
PMI Invoice

**X** \_\_\_\_\_  
Signature

**X** \_\_\_\_\_  
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.

## Billing Information

### Billing Information

Name: _____		
Address: _____		
City: _____	State _____	Zip code: _____
Phone: (____) _____	Fax: (____) _____	
Cell Phone: _____	Email: _____	

### Shipping Information

Employer/Organization Name: _____ <i>(if applicable)</i>		
ATTN: _____		
Address: _____		
City/State: _____	Zip code: _____	
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
<b>1</b>				
<b>2</b>				
<b>3</b>				

Approved by: \_\_\_\_\_

**Credit Card Information (1<sup>st</sup> 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 (2<sup>nd</sup> 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:*

Accounting Department  
Email: [info@pmiMD.com](mailto:info@pmiMD.com)  
Fax: 210.691.8972  
Inquiries: 800-259-5562