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:

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 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 ________________________________  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.
Billing Information

**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:** ________________________

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**Do not write below this line**

<table>
<thead>
<tr>
<th>PAYMENT</th>
<th>AMOUNT</th>
<th>DATE CHARGED</th>
<th>REFERENCE #</th>
<th>AUTHORIZATION CODE</th>
</tr>
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<tr>
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</tr>
<tr>
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<tr>
<td>3</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Approved by: ________________________________
Credit Card Information (1\textsuperscript{st} card)

Use for Payment date(s): ______________________________________________________________

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<thead>
<tr>
<th>Card Type:</th>
<th>☐ VISA</th>
<th>☐ MasterCard</th>
<th>☐ American Express</th>
</tr>
</thead>
<tbody>
<tr>
<td>Card Number:</td>
<td></td>
<td></td>
<td>Security Code:</td>
</tr>
<tr>
<td>Expiration date:</td>
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<td>Cardholder:</td>
<td></td>
</tr>
<tr>
<td>Cardholder Billing Address:</td>
<td></td>
<td>Apt/ Ste/PO Box______</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td>State</td>
<td>Zip code</td>
</tr>
<tr>
<td>Cardholder Contact Number (____)</td>
<td></td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

Credit Card Information (2\textsuperscript{nd} card)

Use for Payment date(s): ______________________________________________________________

<table>
<thead>
<tr>
<th>Card Type:</th>
<th>☐ VISA</th>
<th>☐ MasterCard</th>
<th>☐ American Express</th>
</tr>
</thead>
<tbody>
<tr>
<td>Card Number:</td>
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</tr>
<tr>
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<td>Cardholder:</td>
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</tr>
<tr>
<td>Cardholder Billing Address:</td>
<td></td>
<td>Apt/ PO Box#______</td>
<td></td>
</tr>
<tr>
<td>City:</td>
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</tr>
<tr>
<td>Cardholder Contact Number (____)</td>
<td></td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

Please fax or scan/email the completed form to:

Accounting Department
Email: info@pmiMD.com
Fax: 210.691.8972
Inquiries: 800-259-5562