Gagneja Health
Priti Gagneja, MD FACP

Subscription Billing Authorization Form

1 Participation

I agree to the terms of participation concerning annual subscription/retainer billing-separate from and in addition to fee-for-service payments under Med·care or other insurance programs.

2 Patient Information

Please print:

Full Name(s): _____ Home Phone: _____

Street Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Work Phone: _____

3 Payment Preference

Choose either option:

☐ CHECK - Please make payable to Priti Gagneja, MD and return with this form

Amount: _____

☐ CREDIT CARD PAYMENT - Please select monthly or yearly payment by credit card below

☐ VISA ☐ MC

Name (as it appears on card): _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____ Exp. Date: _____

CVC Code: _____

I authorize Priti Gagneja, MD to automatically charge my fee to the credit card indicated below. This authorization shall remain in effect until Dr. Gagneja has received a written termination notice from me and has had reasonable time to act upon it.

◯ Amount per month: _____ OR

◯ Amount per year: _____

Account Holder Signature: _____ **Today's Date:** _____

Please mail your completed Subscription Billing Authorization Form to:
Priti Gagneja, MD FACP
2323 De La Vina St., Suite 207
Santa Barbara, CA 93105