



Credit Card Authorization Form

We accept Visa, MasterCard, Discover and American Express.

Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ E-mail address: _____

Card Number: _____ Exp. Date: _____

CVV Code: _____ Zip Code: _____

* A receipt will be sent to the e-mail address that is provided above. Please check spam and junk folders.

Did you know you can pay your dues online? Visit www.sceyedoctors.com and select "Pay Membership Dues" option listed below the SCOPA logo.

SCOPA Payments - I would like my credit card charged:

- Annual dues payment** in the amount of \$ _____
Your card will be charged on March 15th.
- Quarterly dues payment** in the amount of \$ _____
Your card will be charged on the 15th of the following months: January, April, July and October.
- Biannual dues payment** in the amount of \$ _____
Your card will be charged January and July 15th.
- One-time** payment to the SCOPA (meeting, dues, balances): \$ _____

Please check this box if you would like your card updated with both SCOPA and SCOPA – PAC accounts.

Please complete this entire form in order to authorize the SCOPA to set up your recurring draft or for any one-time payments you would like to issue on your card. If your card expires while on a recurring draft or does not run for another purpose, the SCOPA will send you an invoice in the mail and e-mail. **Thank you for your membership!**

Signature: _____ Date: _____