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:** ____

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

☐ ***Please check here if this card is used for both SCOPA and SCOPA – PAC.***

SCOPA Payments - I would like my credit card charged:

- ☐ ***Annual dues payment*** in the amount of $______________
  Recurring annual payment will process January 15th. All annual payments are due by 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 on the 15th January and July.
- ☐ ***One-time*** payment to the SCOPA (keep card on file for future authorized payments): $______________
- ☐ ***One-time*** payment to the SCOPA – do not keep card on file: $______________

Please complete this entire form in order to authorize SCOPA to set up your recurring draft or for any one-time payments you would like to issue on your card. You may also go online at www.sceyedoctors.com and complete payment in "Pay Membership Dues" section. 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. ***Thank you for your membership!***

Signature: ____ **Date:** ________________________

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