



RED FLAGS PAYMENT PERMISSION FORM

To be completed by the person whose name appears on the Form of Payment.

I, _____, give permission for,
(Name of person on form of payment)
_____, to use my Medical
(Printed name of patient)

Flex card, personal credit card, or personal check to pay for the services that they receive at the Medical Clinic of North Texas.

Please provide the last **4 digits** of the card number or bank account that will be used for transactions.

FlexMed Card

Expiration Year

Credit Card

Expiration Year

Bank Account

I understand that the information provided in this document will remain in effect until expiration dates indicated above or until written letter is provided to the Medical Clinic of North Texas to either void or terminate this agreement.

Guarantor's Printed Name

Dependent's Name

Guarantor's Signature

Date

Witness

Date