Advanced Medical Transport
of Central Illinois
Save Lives. It's what we do.

Authorization and Agreement

This form, completed in its entirety, will authorize Advanced Medical Transport to process a credit card payment monthly as authorized below.

I hereby authorize Advanced Medical Transport to post the below amount to my credit card as specified below. I understand that I am in full control of automatic payments. I may discontinue enrollment at any time by calling Advanced Medical Transport @ (309) 494-6203 or (855)268-2455. If I have signed up for monthly payments and need to stop them for any reason I can.

Simply complete this form and either mail it back to:
Advanced Medical Transport
1718 N Sterling Avenue
Peoria, IL 61604
Or
fax it to: (309) 494-6537

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Phone number to call if we have any questions or issues processing this request: _____
Account/Run #:_____

Circle which credit card you will be using: Visa MasterCard Discover American Express
Name as it appears on the credit card: _____

Card #: _____
Expiration date: _____
Zip Code of the cardholder: _____
Security code as shown on the back of the card: _____

Monthly payments of: _____ to be applied on this day of the month: _____
(If this date falls on a weekend, it will be ran thru on the Monday after that date.)

If your credit card company denies your payment, we will attempt to process it for 3 consecutive days. On the 4th day, you will receive a collection notice if we haven't had any contact with you for a resolution.

Signature: _____ Date: _____