

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

### CREDIT CARD PAYMENT

For your convenience, we request a credit card number on all records for any un-paid balances.  
This will be used to cover any deductibles and/or patient balances after insurance.

Master Card \_\_\_\_\_

Visa \_\_\_\_\_

Discover \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Payment Amount: \$ \_\_\_\_\_

Please call to authorize payment on credit card on balance after insurance pays  
Automatically bill any balance to my credit card

Cardholder's Signature: \_\_\_\_\_

PAYMENT  
DEPOSIT

PHONE PAYMENT

PAYMENT TAKEN BY: \_\_\_\_\_