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Payment Plan Agreement

I (your name)_____ agree to pay my balance by check or credit card the amount of $_____on the 15th of each month until the balance is zero. If paying by credit card complete

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information			
Card Type: ☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
☐ Other _____			
Cardholder Name (as shown on card): _____			
Card Number: _____			
Expiration Date (mm/yy): _____			
Cardholder ZIP Code (from credit card billing address): _			

I, (full name on the card name)_____, authorize (name of your provider) _____to charge my credit card above for agreed upon professional services. I understand that my information will be saved to file for future transactions on my account.

Patient Signature
Date
Address