SKIN CANCER & DERMATOLOGY CENTER OF COLORADO SPRINGS

PATIENT PAYMENT PLAN

Patient's Name _____ Date of Birth _____

Account Number _____ Date of Service (s) _____

Your account has an outstanding debt for medical services rendered on the date(s) listed below. You may receive a statement on the first of the month. You must return payment within **fifteen (15)** days or you may choose to set up an **Easy Pay Method**. We bill your credit card once for the full amount, or every month on the 1st or 15th of month for a maximum of three (3) months for the specified amount per the agreement. This form may be used if you wish to have a credit card on file for future payments. Please check on of the radio button below.

- ◯ Monthly – 1, 2, or 3 (circle one) months on the 1st or 15th of the month (Circle One)

  In the amount of $ _____

- ◯ One-time payment only in the amount of $ _____

- ◯ Credit card on file from _____ to _____ (Please put in a date range.)

I understand that this form is valid unless I cancel the authorization through written notice to the health care provider.

Cardholder Signature _____ Date _____

Cardholder Name, as it appears on the card:			
Cardholder Address:			
City:		State:	Zip:
Credit Card Number: _____/_____/_____/_____	☐ Visa ☐ MasterCard ☐ Discover ☐ American Ex	Expiration Date:	CCV Code:

Please return form to:
Skin Cancer and Dermatology Center / 595 Chapel Hills Drive Suite 303 / Colorado Springs / CO 80920
Phone: 719-574-0310 / Fax: 719-593-5947

03/2017 tkd