All About Women

Payment Arrangement Form

Patient Name:_____ DOB: _____

Card Holders Name: _____ Phone: _____

Total Amount Due: _____ Zip Code: _____

Credit Card #: _____ Exp. Date: _____

Visa: _____ Master Card: _____ Discover Card:_____ Sec. Code: _____

Amount to be Paid: _____ When: _____ Freq.: _____

Beginning on: _____ Pt. will be paying by: CC_____ Check_____ Cash_____

I agree to allow All About Women Health Assoc., Inc, to charge my credit card, or have my payment in the office, for the agreed upon amount, date and frequency stated above.

Signature: _____ Date: _____

Office Use:

Recurring Payment set up on: _____ by:_____

Amount of Payment: _____ How many payments: _____ Beginning:_____

Recurring ID#: _____