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#: ___________________