Pre-Authorized Payment Plan Form

Patients Name: ___________________________________
Parent/Guardian Name: ____________________________
Address: ____
Phone Number: ___________________________________

Payment Account Information

Name on Card: ________________ Last 4 of Debit/Credit Card Number: ________________

Expiration date: _____________ Security Code: _______________

I hereby authorize Clackamas Oregon Pediatrics to charge my account listed above for:

◯ ___ consecutive payments of $______

◯ Until the amount of $______is paid in full.

◯ Until I have paid $______

I understand that I am responsible for keeping adequate fund in the account mentioned above; any fees accrued due to payments made will be my responsibility.

Examples:

- 10 consecutive payments of $50.
- Until the amount of $150 is paid in full.
- Until I have paid $300

Signature of Card Holder: _________________________ Date: ______________