PAYMENT PLAN FORM

This consent is valid for ***TWO*** years unless it is cancelled through written notice by the cardholder.

After two years, a new credit card consent form will need to be filled out.

Patient(s) Name(s) _____

Account Number(s) _____

I authorize DuPage Pediatrics, Ltd. to charge my credit card as listed below.

Cardholder Signature _____ Date _____

Cardholder Name as Listed on the Credit Card _____

Cardholder Address _____

Contact Phone Number _____

Credit Card Number _____

Expiration Date _____

Type of Card _____

Dollar Amount _____

Frequency of Charge _____

Processing Date Each Month _____

(The credit card will be charged at 1:00am on the date listed)

Current Balance _____

☐ Please check this box if you wish to have any new balances charged once your current balance is paid off. The consent is valid for two years.

☐ Please check this box if you only wish to pay off the current balance.