

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.

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 _____

Account 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.