



Payment Agreement

In consideration of services rendered to _____ (name) on
_____ (date of service) I agree to the following payment arrangements:

Michael Robinson Family Medical Clinic has the authority to charge the credit card listed below to satisfy the Patient Obligation.

Payments will be made as follows:

Payment/Installment amount: _____

Total amount authorized to charge: _____

Credit Card will be run (Check one)

One time only Monthly - 1st of Month Monthly - 15th of Month

Name on Credit Card: _____

Mastercard Visa AmEx Discover

Credit Card Number: _____

Zip code: _____ Exp. Date: _____ CVV/CVC: _____

If payment is denied by a bank or credit card company, the patient will be obligated to pay their entire outstanding bill prior to service.

Patient/Responsible Party Signature

Date

1221 Colorado Ave

Elk City, OK, 73644

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