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

1900 W 2nd St. Suite A
Elk City, OK, 73644
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