Payment Plan - Credit Card Authorization

NOTE: PAYMENT PLANS ARE AVAILABLE ONLY FOR CO-PAYS / DEDUCTABLES (THEY ARE NOT AVAILABLE FOR SELF-PAY / CASH-PRICE CLIENTS)

In an effort to help manage the increasing burden of payment responsibility upon the patient Valley Radiology Consultants Medical Group, Inc offers payment plans for any co-pays / deductible that are over $100. The total amount due can be split into the maximum of three (3) payments with at least one payment per month. Today's payment must be run in Zirmed as per normal protocol.

Patient Name: _____

Patient Account Number: _____

Patient Appointment Number: _____

Date of Service: _____

Patient Phone Number: _____

Account Type: ☐ VISA ☐ MASTERCARD

Card Number: _____

Exp. Date: _____ Card Security Code (CSC): _____

Name on Card: _____

Address Associated with Card: _____

_____

Total Amount Due	

	DATE	AMOUNT	REMAINING BALANCE
Today's Payment			
2nd Payment			
3rd Payment			$0

I hereby authorize MSN, on behalf of Valley Radiology Consultants Medical Group, Inc, to charge the credit card indicated in this authorization form according to the terms outlines above. I understand that the authorization will remain in effect until the debt is fully discharged and agree to notify the business in writing of any changes in my account information.

_____

Card Holder's Signature

FAX ATTENTION: MANDY MATTHEWS AT MSN EACH NIGHT 800 656 0592