FAVORED
MEDICAL BILLING

Fax Number: 1.623.374.4592
(the 1 is required in front)
Email: info@favoredmedicalbilling.com
Phone: Kashuna at 623.322.0730

Payment Plan and Credit Card Form

Provider Name: _____

Patient Name: _____

Date of Service to Apply Payment: _____

Patient Address/Telephone: (verified, no changes)

_____

_____

Card Type: VISA MasterCard Discover Care Credit

Card#: _____ Exp. Date: _____

Security Code: _____ Zip Code: _____

Payment Amount: _____

Receipt to be Mailed: ___ YES
___ NO

Payment Plan: Auto Debit

I, _____ agree to the below outlined payment arrangement to satisfy the current outstanding balance on my account.

Payment Amount: _____

Arrangement Start Date: _____

Payments shall be run: ___ Biweekly (on Fridays)
___ Monthly (the 28th of each month)

Signature of Responsible Party: _____ Date: _____