DESERET FAMILY MEDICINE

GREENFIELD OFFICE
1425 S GREENFIELD RD #101
MESA, AZ 85206

GOLD CANYON OFFICE
6410 S. KINGS RANCH RD #1
GOLD CANYON, AZ 85118

PAYMENT PLAN FORM

I, _____ understand that I am financially responsible for all Charges
Patient Name/ Responsible Party

incurred by myself/family _____. I agree to pay for the Balance in full
Patient Name

within the next _____. The total balance is $_____
days/months

Please **PRINT** the following information.

_____
Patient Account Number

_____
Name

_____
Patient's DOB

_____
_____
Phone Number

_____
_____
_____
Address

_____
Please Initial

I authorize Deseret Family Medicine to charge my credit card once per month either on the 10th or 25th as indicated below. Your last bill could be less so that you do not pay more than the total balance.

Visa Mastercard American Express Discover

_____
Card Number

_____
Expiration Date / Security code

_____
Name as it appears on your credit card

_____
Signature

_____
Please Initial

I agree to pay $_____ per month.

_____
Please Initial

I authorize Deseret Family Medicine to charge my credit card once per month on
10th or 25th (Please Circle one.)

_____
Please Initial

A receipt will be mailed upon request. Please Circle Yes or No

_____
Please Initial

I understand that failure to make this payment or my charge card declining could result in my account being turned over to an outside collection agency with all applicable fees.

_____
Please Initial

I refuse to keep my credit card number on file and accept responsibility for any unpaid balances and any applicable collection fees.

By signing this I agree to all of the above terms and conditions.

_____
Signature

_____
Date

_____
Employee Initials