(312) 750-9000
www.datmp.com

Patient Payment Plan Authorization

Payment Schedule: Please mark [x] in one or both of the boxes

[ ] 1st of the month [ ] 15th of the month

Total Amount Due $_____

Scheduled Amount $_____

Paid in Full by:_____/_____/_____

PAYMENTS MADE ON DATES THAT FALL ON A WEEKEND OR HOLIDAY MUST BE PAID ON THE NEXT BUSINESS DAY

Monthly Payments paid via:

[ ] Check (In this office on the_____of the month)
[ ] Cash (In this office on the_____of the month)
[ ] Pay by Text
[ ] Credit Card
[ ] Visa [ ] Mastercard [ ] American Express [ ] Discover

****We must hold a credit card on file, regardless of payment method.****

Name on Credit Card: _____

Card Number: _____

Expiration Date:_____/_____ CVC Code: _____

Address of Credit Card: _____
Street Address

_____ _____ _____
City State Zip code

Signature: _____

Today's Date: ____/_____/_____