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: ______________