PATIENT PAYMENT PLAN

Patient Name: _____ DOB: _____

Total Balance: $_____

Monthly Payment (Second Friday of the month): $_____

Recurring payment date: _____

Payments will continue until the agreed balance is paid in full.

Credit Card Authorization

I authorize Arizona Endocrinology Center to securely keep my payment authorization on file and charge the credit card listed below for the agreed payment amount and schedule.

Card Type: ☐ Visa ☐ Mastercard ☐ AmEx ☐ Discover ☐ Other

Cardholder Name: _____

Card number: _____

Expiration Date: _____ CVC# _____

Payment Agreement

I understand that I am responsible for paying my outstanding balance according to this payment plan. I agree to contact Arizona Endocrinology Center with any billing questions or concerns so they can be reviewed and addressed.

This agreement does not waive any rights I may have to dispute an unauthorized or incorrect charge under applicable law or card-network rules.

I authorize the recurring payments described above until the agreed balance is paid in full, subject to applicable cancellation and payment authorization requirements.

Patient Signature: _____ Date: _____

Payment processed by: _____