PHONE/ ONLINE/ FUTURE DATE PAYMENT FORM

DATE: ________________

RCSC Staff Member Who Took Call:________________________________

Patient Name: ____

Procedure: ____

Payment Amount: ____

Card Number: ____

Card Holder Name: ____

Card Type: (Circle one) **VISA** **MasterCard** **American Express** **Discover** **Care Credit**

Care Credit Payment Options: 6 No Interest 12 No Interest W/ 5% Processing Fee **Extended Plans:** 24 36 48 60

Expiration Date:_________________________________ **Security Code:**_____________

Zip Code:_____________________________________

Comments: