Valley Internal Medicine and Pediatrics

708 Will Hasley Way, Suite A

Madison, Al 35758

Charge Agreement/Payment plan:

Patient Name: _____ Todays Date: _____

Responsible party_____ Relationship_____

Phone Number_____

Payment agreement and dates etc

_____

_____

Credit card type_____ Name on card_____

Card Number_____ Security code_____

Zip Code_____ Exp Date_____

By signing the below, I am agreeing to the payment plan as above. All info on this sheet will be kept private with Manager.
Transactions ran the morning of.

Signature of responsible party_____

Date_____