PATIENT PAYMENT
AGREEMENT

Patient: _____

DOB: _____

Agreement to Pay for Physician Services / Credit Card Payment Authorization

I agree to pay for the services rendered by Benjamin Eye Institute as indicated below.

Date of Service: _____ **Description:** _____

Total amount: _____ **Down payment paid:** _____ **Date:** _____

Balance: _____

I authorize Benjamin Eye Institute to charge my Payment Method on File such as Debit Card or Credit Card or Credit Card info given over the phone.

- ☐ For the full balance of agreed service
- ☐ 3 Monthly payment arrangement

First payment on: _____

Credit Card:

- ☐ Visa
- ☐ MasterCard
- ☐ Amex

Name as appears on card: _____

Card Number: _____ **Exp.** _____

Billing Zip Code: _____ **CVV.** _____

If my payment company or bank denies payment, **I agree to pay the entire amount promptly** (within) 10 days via another form of payment.

If the patient misses payments, without prior notification and agreement, the practice reservers the right to transfer collections to a collection agency.

Name of Credit Card Holder: _____

Address: _____

Phone: _____

Signature: _____

Current Date: _____