Contract for Payment

Date:___________

Patient Name:____
Cardholder Name:____
Visa/Mastercard (please circle) Number:________________________________
Expiration Date:_______ V-Code:________ Billing Zip Code:___________

I authorize my credit card to be billed for copays, ancillary charges, and services rendered at Poehailos, Dupont and Associates that are not covered by my insurance.

_________________________ ____________________
Signature of Guarantor Date

_________________________ ____________________
Signature of Cardholder Date
(if different from guarantor)