PATIENT PAYMENT PLAN

Patient ID: ______________________________ (Account # from Metropolitan)

First Name: ______________________________ Last Name: ________________________________

Payment type: ☐ Credit Card

Card Number: ____ Exp. Date: ________________

Card Holder Name: ____ Zipcode: ________________

Email Address: ____ CVV: ________________

Total Balance: ______________________________________

Initial Payment Amount: ______________________________________

Monthly deduction: __________________________________ Start Date: ___________________