ADVANCED ANKLE & FOOT SURGEONS, LLC

Agreement to Pay for Services

Patient Name _____ **Date of Birth** _____

Responsible Party _____ Date of Birth _____

- I agree to remit the following payments to **Advanced Ankle & Foot Surgeons, LLC** for the services provided to the patient named above.
- I understand that if I miss any payment, without prior notification and agreement, the practice reserves the right to transfer collections to a collection agency and Dr. Taylor may ask that I find another source for my podiatric medical care.

	PAYMENT AMOUNT	PAYMENT DUE DATE
Payment in Full		
Payment 1		
Payment 2		
Payment 3		
Payment 4		
Payment 5		
Payment 6		

_____ _____

Signature of Patient/Responsible Party (if other than patient) Date

_____ _____

Print Name of Patient Print Name of Responsible Party

Credit Card Information:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number _____ Expiration Date _____

Name as it appears on card _____ Billing Zip Code _____

I authorize Advanced Ankle & Foot Surgeons, LLC to keep my signature on file and to charge the payments indicated above to the credit card selected above

_____ _____

Signature of Responsible Party/Cardholder *Date*

_____ _____

Print Name of Responsible Party/Cardholder *Phone Number*