CHUNG MEA HA, MD, PC

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PATIENT PAYMENT

Date: _____ Account Balance: _____ Account # _____ □ Med Ease □ Allegiance

Patient: LAST _____ FIRST: _____ DOB: _____

Payment From: _____ Relation: _____ Phone: _____

Amount: _____ □ Cash □ Check □ Credit Card / □ Balance □ CoPay □ CoInsur / Deduct □ Pre-Pay

CREDIT CARD PAYMENT: (**NOTE: $30.00 FEE** FOR **TWO** DECLINED TRANSACTIONS)

Card Holder Name: _____ Phone: _____

Card Holder Address: _____

Credit Card #: _____ Exp Date: _____ CVV Code: _____

□ Visa □ Master Card □ AMEX □Other: _____

CHECK PAYMENT: (**NOTE: $30.00 FEE** FOR **ONE** DECLINED CHECK)

Bank: _____Check Number: _____

Routing: _____ Account: _____

PAYMENT PLAN: Confirmation Call: □ YES □ NO / Mail Receipt: □ YES □ NO

Down Payment: _____ Monthly Payment: _____ Monthly due date: _____ Recurring for __ Months

BEST CONTACT INFORMATION: Phone: _____ Time: _____

Patient/ Responsible Party: _____ Date: _____

□ I received a copy of this document (initial): _____

□ I am aware of the fee policy for declined credit cards or checks (initial): _____

Staff Signature: _____ Date: _____