

Mountain Sleep Diagnostics Payment Plan Consent form

I, _____ (Please Print Name) understand that by signing this Consent Form I allow MOUNTAIN SLEEP DIAGNOSTICS to automatically charge my Credit Card / Account on the following dates listed below for the corresponding amounts. I also understand that if any transaction is delayed or declined due to my own actions or errors, I will immediately be sent to collections for the remainder of the outstanding balance.

I agree to the following charges on the corresponding dates. To associate with the following Card / Account.

Card # _____ Card Holder: _____
EXP: __/__/__ CV2 _____ Billing Address: _____
City: _____ ZIP: _____

On __/__/__ amount charged \$ _____

On __/__/__ amount charged \$ _____

On __/__/__ amount charged \$ _____

The Total for payment Plan \$ _____.

Signature _____ Date _____

For Office Use Only

Plan Approved By: _____ Date: _____

Payment Taken By: _____ Date: _____

PT ID#: _____ PT DOB: __/__/__ PT Name: _____