MEMORIAL AND KATY SURGICAL SPECIALISTS
General, Breast and Laparoscopic Surgery

I understand the balance due is for services performed by Memorial and Katy Surgical Specialists and is my patient responsibility. I understand this form is valid until the balance is paid in full. This agreement becomes invalid if terms are not met by the patient/parent/responsible party and the discount will be voided. Memorial and Katy Surgical Specialist will take appropriate action to collect the full amount due.

Your balance due ______________________if paid in full within 3 months of starting the payment plan on _________________ you will receive a 50% discount. However, if you do not complete the payment plan within the requested time you will be responsible for the total amount due.

Procedure: ___________________________

Total Amount Due: _____________________

Initial Payment Made: _________________

Balance Due: ________________________

Payment Options:

Weekly: I will make my payment each week on (day of week) _____________________.

Bimonthly: I will make payment on _________ and __________ of each month.

Monthly: I will make payment on ________ of the month.

Charge the complete balance on (date) _________________.

Patient Name				
Cardholder Name				
Cardholder Address				
City, State, Zip				
Card Type	American Express	Discover	Mastercard	Visa
Credit Card Number				
Expiration Date				
Security Code				

____ ________________

Patient or Responsible Party Signature Date

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