Keith P. Smith, M.D., F.A.C.S.
General Surgery

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RECURRING PAYMENT CONSENT

Patient/Responsible Party Name:

Balance Due as of:

RECOMMENDED PLAN

☐ I authorize Keith P. Smith MD, LLC to keep my signature-on-file and to charge my credit/debit card for _____ **recurring payments of $__________ per month, with a final payment of $__________**. This authorization will be effective as of __________________, and will continue monthly until the balance of **$**___________ has been paid in full.

CUSTOMIZED PLAN

☐ I authorize Keith P. Smith MD, LLC to keep my signature-on-file and to charge my credit/debit card for _____ **recurring payments of $__________ per month, with a final payment of $__________**. This authorization will be effective as of __________________, and will continue monthly until the balance of **$**___________ has been paid in full.

WAIVER

☐ I do not wish to participate in an automatic payment plan.

CardHolder Name: ____

Credit/Debit Card Type: ☐VISA ☐MasterCard ☐Discover ☐ Other: __________________

Card Number: ______________________________ Expiration: ____ / ____

Security Code: ________

______________________________ ____________
Patient/Account Holder Signature Date

*Individual Payment Dates can be changed with sufficient prior notice
**The total balance due can be paid at any time, therefore voiding this payment plan.