MedDraft™

MedDraft Automated Payment Plan Form

Summit View Surgery Center
Client Number: 132USP
7730 South Broadway
Littleton, CO 80122

*Please fax form to **(949) 900-6131** to begin enrollment*

Patient Toll Free Number: (866) 658-5523

PATIENT INFORMATION

Date of Service

Name (Last, first, middle initial)

Patient Account Number

☐ Patient is a minor.

Street address, City, ST, ZIP Code

Patient Date of Birth

Primary phone number | Other phone number

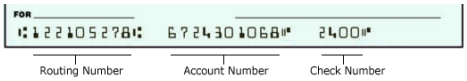
Email Address

Responsible Party/Guarantor Name (if patient is a minor)

Type of Account

☐ New Account ☐ Add to Existing Account ☐ Replace Existing Account

METHOD OF PAYMENT (Credit Card or Checking)



Name of Payer/Account Holder

MasterCard VISA DISCOVER AMERICAN EXPRESS

Bank Routing Number (9 Digits)

Credit Card Number

Bank Account Number

Expiration Date

Name of Bank

PAYMENT INSTRUCTIONS

Estimated Amount Due: $_____

If my total responsibility after insurance is higher than my estimate, I would like my MedDraft account to extend to cover the full balance. Initial Here: _____

Payment Amount*: $_____

*Amount will draft monthly, unless otherwise specified below.

Payment Plan to begin on _____
Date

Optional Payment Schedules:

☐ Every Other Week (Day of the week: _____) ☐ Weekly (Day of the week: _____) ☐ Twice per Month (Dates: _____ & _____)

FINANCIAL AGREEMENT

By signing below I hereby authorize the above named entities to draft funds electronically from my account on a monthly basis or as indicated and instructed above. I further acknowledge that a default in these terms will void the payment plan above and the balance in full will be due. I will assume responsibility for any insufficient fund fees, collection cost and/or reasonable attorney fees and court costs associated with collecting the balance. Returned checks and/or credit card disputes will result in a $20 fee. Withdrawals will read MedDraft. By providing my contact information I agree to be contacted as needed through various communication(s) either directly or by 3rd party billing agents, which includes but is not limited to use of Phone, Cell, Email, Text, artificial voice messaging and auto dialing technologies. Messages may include my name, Medical Practice name and/or any relevant Billing Agents. Overpayments resulting from insurance adjustments will be refunded by the medical facility. I understand that this authorization will remain in full force and effect until I notify MedDraft by phone at (866) 658-5523 that I wish to revoke this authorization. I understand that MedDraft requires at least five (5) days prior notice in order to cancel this authorization.

Patient Signature

Date

REGISTER TO VIEW YOUR ACCOUNT ONLINE AT WWW.MEDDRAFT.COM