



# Maitri

## Payment Plan Authorization

If you have an outstanding balance we can set-up a payment plan that will automatically debit your credit card or bank account on a monthly basis. We offer a maximum of 6 months for a payment plan. Payments are automatically processed on the 1st of each month. \*Please Note: We do NOT accept American Express.

**Any balance greater than 60 days will disqualify patients from scheduling new appointments until the balance is paid in full.**

To be completed by office staff:	Patient Acct # _____
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Current Balance:	_____
Payment Amount:	_____

Start Date for Auto Payment:	_____	End Date for Auto Payment:	_____
Staff Initials:	_____	Date:	_____

I authorize Maitri Health Care for Women to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Credit Card

Debit Card

Credit/Debit Card Number: \_\_\_\_\_

CVV (3 or 4 digit number on back) \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I, the undersigned, authorize and request Maitri Health Care for Women to charge my credit card, indicated above, for the balances due for services rendered that my insurance company identifies as patient responsibility.

This authorization will remain in effect until the balance is paid in full.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_