Payment Plan Application

Cape Cod Pediatrics
Boston Children's
Primary Care Alliance

capecodpediatrics.com
508-477-5306 | *fax* 508-477-0297

Patient information

Last name: ____

First name: _____________________________________ MI: _____

Date of birth: ____

Payment information

Credit card number: ____

❍ VISA ❍ MC ❍ AMX ❍ DISC

Cardholder name: ____

Expiration date: ______________ CCV code: ____________________

Monthly payment amount: __________________________________

Please bill my payment on the ___________ of each month
DAY

Email address: ____

Signature: ____

Date: ____

A payment plan agreement will be emailed for you to accept and sign.