Patient Payment Form

***** If not done previously so that we have one file, please complete and sign the following, then submit the completed form via email to gawdibella@yahoo.com. Copays are due PRIOR to appointment.*****

Patient's Name: ______________________________

Date of Birth: ______________________________

______________ ______________

Payment Type: ☐ Visa ☐ Mastercard ☐ American Express

☐ Other: ______________________________

Card Number: ______________ **Exp:** ________ **CVV:** ________

Name on Card: ______________________________

By signing this form, you are hereby authorizing Optilife to charge your card, listed above, for all charges, present and future, you incur with Dr. Di Bella from the office. You also agree to keep us updated with any changes.

Signature: ______________________ **Date:** ______________