Sunrise Ambulatory Surgical Center
5448 South Highway 260 • Suite 100 • Lakeside, AZ 85929
(928)532-3010 • (928)532-1161 *fax*

Payment Schedule

Date _____

Patient Name _____ **Account #** _____

Balance Due $ _____

1st Month $ _____ ☐ Credit Card or ☐ Check # _____ Dated _____

2nd Month $ _____ ☐ Credit Card or ☐ Check # _____ Dated _____

3rd Month $ _____ ☐ Credit Card or ☐ Check # _____ Dated _____

4th Month $ _____ ☐ Credit Card or ☐ Check # _____ Dated _____

5th Month $ _____ ☐ Credit Card or ☐ Check # _____ Dated _____

Supervisor Approval _____

Credit Card ☐ Visa ☐ MC ☐ Discover ☐ AMEX

Number _____ - _____ - _____ - _____ Exp _____ - _____

Comments _____

_____

_____

By signing below, I acknowledge that I understand and agree with the schedule indicated above. Furthermore, I hereby authorize *Sunrise Ambulatory Surgical Center* to charge my credit/debit card or deposit my checks based on the schedule listed above.

X _____ _____
Signature Date