



## Wakefield Family Medicine, PLLC

131 Meadow Street Sanbornville, NH 03872  
Office Phone: (603 )871-8227 – Office Fax: (603) 871-8285

### Financial Consent- Credit Card Processing

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Date: \_\_\_\_\_

#### Credit Card Information

Type of Card: \_\_\_\_\_

CC #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_ CCV: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Signing below confirms customer consent to process outstanding patient balances and/or co-payments on the above listed credit card at the time of service or balance due date.

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

Receipt will be emailed or mailed home after successful processing.

This CC may be removed or cancelled from use at anytime. Please notify the office.