St. Cloud Surgical Center

1526 Northway Drive
St. Cloud, MN 56303
Ph: (320) 251-8385
Fax: (320) 251-1267

Date: _____

You have the option for us to automatically apply a payment to your credit card or automatically withdraw a payment from your checking account.

Please fill out the bottom portion of this form with the requested information regarding your account and return it to St. Cloud Surgical Center. Once we receive the signed form, we will set up automatic payments as you've requested.

Thank you,

St. Cloud Surgical Center
Business office

Please fill out and return this portion in the envelope provided.
If setting automatic payments for more than one account, please fill out one form for each patient.

Patient Name:_____

Patient Account Number:_____

Payment Amount $_____to be applied on the _____of each month.

Checking Account: Routing #_____Account #_____

Credit Card (circle): Visa Mastercard Discover American Express Other:_____

Credit Card#_____Expiration Date:_____

CV2 Code (3 digit code by signature on back of card)_____

Cardholder's Printed Name:_____

Cardholder's Signature:_____