



9040 Town Center Parkway Lakewood Ranch, FL 34202
941.487.3665 | www.rightaccordhealth.com

PAYMENT FORM

DATE: _____

You can make your deposit and/or recurring payments by check or Credit Card. If you choose to pay by one of the following methods, please complete and return as soon as possible. CHECK ☐ CREDIT CARD ☐

Patient/Client Name: _____

Client Address: _____ Telephone #: _____

Representative Details: Invoice to be sent to: ☐ Client ☐ Representative ☐

Name: _____ Relationship: _____

Address: _____

Telephone #: _____ Email: _____

Credit Card Details:

Name on Card: _____

Card Type: Visa ☐ MasterCard ☐ American Express ☐ Discover ☐

Card Number: _____ Expiration Date: _____ CVN: _____

Billing Address: _____
(if different from above)

I authorize Right Accord to debit my credit card weekly for invoices billed.

Client Signature

Representative Signature

Please Note: To secure immediate services, credit card details must be completed. Additional 4% fee per transaction for credit card payments.

Return by email to
admin@rightaccordhealth.com
or fax 941-240-2145

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