MATRIX HEALTH SYSTEMS/OTTER CREEK ASSOCIATES

Please complete this form for credit card payments. Once the form is complete please email to morganwilliamson.vcac@proton.me so it can be submitted for billing.
(VISA, MasterCard, Discover or HSA only)

Cardholder's Name: _____

Cardholder's Street Address: _____

City, State and Zipcode: _____

Email Address: _____

Cell Phone Number: _____

Credit Card Number: _____

CVV: _____

Expiration Date: _____

Amount: _____

Date of Service: _____

Patient: _____

Clinician or Program: _____

How would you like to receive your billing statements?

- ☐ Email
- ☐ Mail
- ☐ Text

For Billing Department:

Batch #:_____ Date: _____