

# MATRIX HEALTH SYSTEMS/OTTER CREEK ASSOCIATES

Please complete this form for credit card payments; once complete, please email a PDF copy to [Aliceschermerhorn.vcac@proton.me](mailto:Aliceschermerhorn.vcac@proton.me) OR drop off/mail a hard copy addressed to Alice Schermerhorn to 86 Lake Street, Burlington VT 05401

(VISA, MasterCard, Discover or HSA only)

Cardholder's Name: \_\_\_\_\_

Cardholder's Street Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

CVV: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Amount: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Patient: \_\_\_\_\_

Clinician or Program: Alice Schermerhorn (VCAC) \_\_\_\_\_

How would you like to receive your billing statements?

- Email
- Mail
- Text

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**For Billing Department:**

Batch #: \_\_\_\_\_

Date: \_\_\_\_\_