

MATRIX HEALTH SYSTEMS/OTTER CREEK ASSOCIATES

Please complete this form for credit card payments; once complete, please email a PDF copy to cherylshive.vcac@protonmail.com OR drop off/mail a hard copy addressed to Cheryl Shive 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: Cheryl Shive (VCAC)

How would you like to receive your billing statements?

- Email
- Mail
- Text

For Billing Department:

Batch #: _____

Date: _____