MATRIX HEALTH SYSTEMS/OTTER CREEK ASSOCIATES

Please complete this form for credit card payments. Once the form is complete please email to alexisjelm@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: _____________

Wondershare PDFelement