



Agreement of membership

Date ___/___/___ Account Number _____

Patient Name _____ DOB ___/___/___

I accept, understand, and approve the monthly charges to my credit card for my membership at The Village Pediatric & Wellness Center.

Parent/Guardian Name _____

Parent/Guardian signature _____

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

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____ Card Security Code _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Type of Visit	Date of Visit	
Well Child Visit		
Sick Visit 1		
Sick Visit 2		
In-house test 1		
In-house test 2		

