

PROVIDENCE HOSPITAL and MEDICAL CENTERS
Patient Payment Distribution Coupon

Patient Name: _____ **Total Payment Amount: \$** _____

(Please record the account numbers and payment amounts that you would like applied to each account number below.)

Account Number	Payment Amount		Account Number	Payment Amount

Payment Method:

Check Enclosed

Credit Card Payment: _____ VISA _____ MASTERCARD

Card Number: _____

Expiration Date: _____ Signature: _____

~~~~~  
 I would like to be contacted by a Patient Financial Services Representative to discuss other payment options. I can be reached at: \_\_\_\_\_ between the hours of \_\_\_\_\_ and \_\_\_\_\_.

**PROVIDENCE HOSPITAL and MEDICAL CENTERS**  
**Patient Payment Distribution Coupon**

**Patient Name:** \_\_\_\_\_ **Total Payment Amount: \$** \_\_\_\_\_

(Please record the account numbers and payment amounts that you would like applied to each account number below.)

| Account Number | Payment Amount |  | Account Number | Payment Amount |
|----------------|----------------|--|----------------|----------------|
|                |                |  |                |                |
|                |                |  |                |                |
|                |                |  |                |                |
|                |                |  |                |                |
|                |                |  |                |                |
|                |                |  |                |                |

**Payment Method:**

Check Enclosed

Credit Card Payment: \_\_\_\_\_ VISA \_\_\_\_\_ MASTERCARD

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

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

~~~~~  
 I would like to be contacted by a Patient Financial Services Representative to discuss other payment options. I can be reached at: _____ between the hours of _____ and _____.