The Village Sleep Lab

1400 US Hwy 441 N, Suite 942
The Villages, Florida 32159
Fax: 1-888-716-2004
Billing Office: 1-888-731-7608

PAYMENT FORM

Please Fax or Mail to us

Payment by: **[ ] Check** **[ ] Money Order**
[ ] VISA **[ ] MasterCard**
[ ] American Express **[ ] Discover**

Name (on card):_____

Card Number:_____

Expiration Date:_____**Security Code:**_____

Billing Address:_____

_____

Amount Paid:_____

Signature:*_____

*By signing this form, you are giving us permission to use your credit card information to pay your patient bill.

Home or Cell Phone with Area Code:_____

Email:_____

Patient Account Number:_____

If you received a statement from us, your patient account number can be found on the statement.

IMPORTANT NOTICE:

Please note that the paid entity on your credit card statement will appear as **"Pediatric Services & Breathing Center."**

Thank you for your payment.