

Smith House Family Health Care Center
39 Farrell Road, Willsboro, NY 12996
Telephone (518) 963-4275, Fax (518) 963-8862

HEALTH CARE DEPOSIT

(Please return with Patient Statement of Release)

Camper's Name: _____ **Date of Birth** _____

I understand that this deposit will be available to my child and only to my child as a credit toward any treatment/urgent care he or she may require from the Smith House Family Health Care Center. I further understand that the Smith House Health Care Center will refund any unused portion of this deposit and will provide me with a statement and receipt for any services rendered by October 31, 2006. I also understand that I may be billed for any service provided that exceeds the above deposit.

Amount Enclosed: \$ _____

Payment Method _____ Personal Check _____ Credit Card _____

Master Card / Visa (circle one)

Name on Card	Card #	Expiration Date	Code on Signature line (see back of credit card)
Signature Authorizing Credit Card Processing			