

PAYMENT PLAN AGREEMENT

I, _____, agree to remit the following payments to _____:

	<u>AMOUNT</u>	<u>PAYMENT DATE</u>	<u>Check #</u>
Pmt 1			
Pmt 2			
Pmt 3			
Pmt 4			
Pmt 5			

This payment plan is **interest free** and free of billing charges for the payment period; however, I understand that in the event any of my payment is ____ days late, _____ will add a monthly **finance charge** to my account in the amount of _____ % (**____% APR**). Finance charges will accrue from the original charge date. This fee is enforced to keep costs at a reasonable level, thus preventing frequent increases in the fees for medical services.

Method of Payment:

_____ Personal Check(s): See information above

Credit Card (Check one):

_____ Visa®

_____ MasterCard®

Credit Card Number: _____ **Expiration Date:** _____

I authorize _____ to keep my signature on file and to charge my payments to the credit card selected above.

Signature of Responsible Party/Cardholder Date

Print Name of Responsible Party/Cardholder Print Patient Name(s)

Address City State Zip

(_____) _____
Phone Number