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**Payment Plan Agreement Form**

**@PRNAME**

@PRADDR1  
@PRADDR2

@PRCITY, @PRST, @PRZIP

@PRPH

**Date**: @TODAY

**Patient Name:** @PNAME2

**Patient Address:** @PADDR1, @PADDR2

**Patient City, State, Zip:** @PCITY, @PSTATE, @PZIP

**Account #:** @PACCT

This document is to act as a set agreement for an approved payment plan based upon policy set by **@PRNAME**. The patient listed above agrees to make payment on the balance of this account as prescribed below.

Payments will be made the **\_\_\_\_\_\_\_\_** day of each month in the amount of **$\_\_\_\_\_\_\_\_**. Should the patient deviate from the prescribed payment plan at any time, including but not limited to: missed payments, late payments, declined payments, or payments not made in full, **@PRNAME** reserves the right to charge interest, penalties, or void the agreement and request full payment on the remaining balance. The account will be paid in full on or before **MM/DD/YY**.

**PAYMENT PLAN DETAILS**

**Payment Plan Balance:** $\_\_\_\_\_\_\_\_\_\_\_\_\_

**Monthly Payment:**$\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Frequency:**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Due Date:**   
\_\_\_\_ of each month

**@PRNAME** is confined to deduct only the minimum payment amount as prescribed above using the patient's credit card information, unless otherwise informed by notification from the patient.

By signing this agreement, you understand and accept the above stated payment agreement. Any missed payments will be subject to our collection process and possible legal fees.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Employee Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date