Payment Plan Agreement

Last name	First name	DOB

Address	MRN

Thank you for choosing **Family Medical Associates, PC** as your health care provider. We are committed to the success of your treatment and care. Payment for services provided is a part of the physician-patient relationship with your doctor. Per the financial policy of the practice, patients and guarantors are responsible for making the necessary payments toward the services they receive. With the changing environment in health care, more responsibility for payment is being placed on the patient in the form of copays, high deductibles and out-of-pocket costs.

At the sole discretion of the practice, we are offering you this opportunity to set up a mutually feasible payment plan for treatment you will receive or have already received. This payment plan agreement authorizes us to obtain and keep your credit or debit card information on file as a convenient method of payment for the services provided. Your credit or debit card will be charged automatically for the negotiated amount, on the mutually agreed date. Continuous periodic installments are required for the duration of time an outstanding balance exists on your account.

In consideration of the practice accepting installment payments toward your balance, you are expected to:

1. Make the payments as agreed upon without default.
2. Make payments until the outstanding balance in your account is zero dollars ($0).

For your convenience, our practice offers this payment plan with no finance or interest charges. If we receive the periodic payments set forth in this agreement, our practice shall not pursue any additional collection actions on your account. However, any default on the terms of this payment agreement shall render the entire outstanding balance due immediately, and payment in full will be expected. A default on the terms of this agreement will result in our practice pursuing collection efforts. If you have insurance coverage, our practice will submit all claims to your insurance for reimbursement.

By signing this agreement, you waive the statute of limitations as a defense to any lawsuit for the collection of any amounts due.

This payment agreement shall be considered binding after the responsible party has signed and dated the agreement and payment authorization overleaf.

I agree to the terms of this Payment Plan Agreement:

Patient signature: ________________________________ **Date:** ____________

Patient name: ________________________________

Credit/Debit Card Pre-Authorization Form

I authorize Family Medical Associates, PC to charge my credit card for the following outstanding balances using the payment method selected below:

☐ Balance remaining after claim(s) is (are) processed, not to exceed $ ________ for:

- ☐ This visit only
- ☐ All visits this calendar year
- ☐ All visits from ____________________ to ____________________
- ☐ Perpetual

☐ Recurring charges of $ __________ to be assessed every ______________ (frequency) until the balance on my account is paid off.

PAYMENT INFORMATION

☐ Visa® ☐ American Express® ☐ MasterCard® ☒ Discover Card® ☐ Other: ____________________

Patient name: ____________________

Cardholder name: ____________________

Cardholder address: ____________________

City: ____________________ **State:** __________ **Zip:** ____________

Credit card number: ____________________

Exp. date: ____________________ **CVV/CVC/CVC2 code:** ____________________

Cardholder signature: ____________________ **Date:** __________

Cardholder name: ____________________