TREASURE COAST Primary Care

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CONTRACT FOR DEFERRED PAYMENT

PATIENT AUTHORIZATION AND NOTICE

This **Payment Plan Agreement** is made and entered into by and between:

_____ _____ _____

Patient Name (print) Date of Birth Phone Number

The person agrees and understands that payment in full is required for **Date of Service**: _____and promises to make payments as per the following agreement until the amount of **$**_____ has been met.

If payment is not made, interest will accrue at 18% per annum.

PAYMENT WILL BE MADE: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

IN THE AMOUNT OF: _____

PAYMENT WILL BE DEDUCTED FROM THE FOLLOWING CREDIT CARD: ☐ VISA ☐ MC ☐ AMEX ☐ DISC

_____ _____

Name As It Appears On Card (print) Billing Zip Code

_____ _____ _____

Credit Card Number Exp. Date CVC Code

PAYMENT PLAN AGREEMENT SIGN-OFF:

I have read the Payment Plan Agreement and I understand and accept ALL its terms in full.

_____ _____

Signature of Payer Date

_____ _____

Approved By (authorized staff member) Date