Payment Plan Agreement

Patient Name_____ Patient DOB_____

Account Balance_____

Our office has contacted you several times in regards to this balance via mail and phone. If you did not receive any correspondence, please update your contact information with the front desk immediately.

OPTIONS:

- Pay Balance in full
- Pay 50% of balance immediately and leave credit card on file to be debited monthly. Minimum $50/month required

Total due today: _____ (50% of balance) + _____ (copay) = _____

I agree to authorize Texas Diabetes & Endocrinology, PA to debit my credit card monthly on the day and the amount listed below until by balance is paid in full.

_____ _____ _____

Credit Card Number Expiration date Security Code

_____

Credit Card Billing Address City, State, Zip

_____ _____

Monthly Payment Amount Day of Month to be debited (cannot be 29th, 30th or 31st)

_____ _____

Signature Print Name

_____ _____

Signature of Witness (Office Staff Only) Printed Name of Witness (Office Staff Only)

_____

Date

If payment is declined, we will make 3 attempts to contact you. If we are unable to reach you, your account will be turned over to a collections agency and you will receive a formal discharge from our office.