**Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Beginning Balance: \_\_\_\_\_\_\_\_\_\_\_\_**

This will serve as a written confirmation of your agreement to pay your account with Pediatric Group Associates. This plan has been offered to you as a courtesy in order to help you meet your financial obligation. Please review the payment plan policy and terms.

Payment Plan Policy and Terms:

1. If you sign up for automatic credit card payments, you agree that PGA will charge the agreed amount as set forth in the schedule below on your credit card you provided to us until your total amount owed to PGA is paid in full.
2. If you incur an additional charge of $500 or greater before your payment plan is paid in full, that additional charge may be reviewed for possible addition to your current payment plan. If approved by our Business Manager, your payment plan will then be adjusted to reflect the additional payments due PLUS your current payment plan.
3. If you are unable to make a payment, you must contact our billing department at least 24 hours before your payment is scheduled to process.
4. You may choose to make additional payments or pay your account in full anytime. Please note that if you choose to make additional payments they will not count towards your future month’s payments.
5. It is your responsibility to keep Pediatric Group Associates informed of any changes to your phone number and address.

Failure to comply with all terms and conditions will render the plan in default. Should you default on your payment plan your account may be turned over to our collections department.

**Patient Name(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Pediatric Group Associates, SC. To automatically charge my credit/debit card (Visa, MasterCard, Discover, American Express, or Health Savings Account):*

* **Weekly in the amount of $ \_\_\_\_\_\_\_ Date to begin: \_\_\_\_\_\_\_\_\_\_\_\_**
* **Bi-Weekly in the amount of $\_\_\_\_\_\_\_ Date to begin: \_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Monthly in the amount of $ \_\_\_\_\_\_\_ Date to begin: \_\_\_\_\_\_\_\_\_\_\_\_\_**
* **One time in the amount of $ \_\_\_\_\_\_\_ Date to begin: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Card Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  **Expiration Date**: \_\_\_\_\_/\_\_\_\_\_ **3 or 4 Digit Security Code**: \_\_\_\_\_\_ **Billing Zip Code**:\_\_\_\_\_\_\_\_\_\_  **Name on Card (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

For your convenience this form may be mailed or faxed to our billing office at the above address.

Thank you!