PAYMENT PLAN AGREEMENT

Last Name First Name DOB

Address Account Number

Thank you for choosing PrimeCARE Medical Clinic as your healthcare 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 the treatment you have received. This payment plan agreement provides you the option to authorize 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 monthly. Continuous periodic installments are required for the duration of time an outstanding balance exists on your account.

In consideration of the practice of 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 outlined 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.

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.

Listed below are our payment plan options:

Balance	Minimum Payment Amount
Under $100.00	$25.00 per month
$100.00-$200.00	$35.00 per month
$201.00-$300.00	$45.00 per month
$301.00 or above	$50.00 per month

I agree to the terms of this Payment Plan Agreement:

Patient (or Guarantor) Signature: _____

Patient Name: _____ Date: _____

PrimeCARE
MEDICAL CLINIC

PAYMENT INFORMATION

My current patient account balance is $_____ as of (date) _____.

Are claims still pending with insurance? (Circle) Yes No

I further understand that if claims are still pending with insurance at this time I may owe an amount in addition to the amount listed above. If I wish to have further balances added to a payment plan, I understand that I will need to complete a separate payment plan form that includes all outstanding balances as of that date.

Patient's (or Guarantor's) Initials _____

Select One of the Two Options Below and Sign as Indicated

☐ I choose to have my debit/credit card information held by PrimeCARE for automatic monthly payments. I understand if my credit or debit card information changes, I must complete a new Payment Plan Agreement promptly for my monthly automatic payments to continue.

___Visa® ___ American Express® ___ MasterCard® ___ Discover Card®

Patient Name: _____

Cardholder Name: _____**Card Number**_____

Expiration Date:_____ **CVV:**_____

Cardholder Address: _____

City:_____ **State:**_____ **Zip:** _____

Cardholder Email: _____ **Cardholder Phone Number:**_____

I agree to a monthly payment of $_____ that will be assessed within 3 days of the 25th of each month, with an email confirmation sent to the provided email address. This agreement will be valid for _____ months or until the balance above is paid in full.

Cardholder Signature: _____ Date: _____

☐ I choose NOT to have my credit or debit card information held by PrimeCARE. I understand that I must provide this monthly payment by mail, telephone, online, or in person. I understand that failure to provide this monthly payment renders this agreement void, and payment in full will be expected immediately.

Patient (or Guarantor) Signature: _____ Date: _____

Patient Name : _____

Witness Signature (PCMC Employee) _____ Date: _____