

Payment Plan Program Application

This is a special program that helps patients get the care they need when finances are an issue. All requests must be approved by the administrative staff. Not all requests are approved.

Staff Person Receiving Request _____ Date _____

Personal Information

Last Name	First Name	Social Security #	Driver's License #
Home street Address		City	State Zip
Home Phone	Cell Phone	Email	

Family Member or Friend

Full Name of a close family member or friend		Relationship to you	
Home street Address		City	State Zip
Home Phone	Cell Phone	Email	

Credit Card Info

Type of Card <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> AmerX <input type="checkbox"/> Disc <input type="checkbox"/> Other		Billing Address for Credit Card	
Name on Card		Street Address	
Card #		City	
Exp Date		State	
Code on Back of card (3 or 4 digits)		Zip	

Please tell us why we should approve your request?	Authorization
	<p>I AGREE TO PAY THE AMOUNTS INDICATED BELOW FOR THE DURATION OF TIME INDICATED BELOW SHOULD MY REQUEST FOR THIS PAYMENT PLAN BE APPROVED. I CHOOSE TO RECEIVE THE SERVICES/PRODUCTS THAT ARE BEING OFFERED BY THIS COMPANY/CLINIC AT MY OWN RISK. NEITHER THE STAFF, ASSOCIATES, OR ANY OTHER PARTY INCOLVED IN CREATING, PRODUCING, OR DELIVERING THE SERVICE IS LIABLE FOR ANY DIRECT, INCIDENTAL, CONSEQUENTIAL, INDIRECT, OR PUNITIVE DAMAGES ARISING OUT OF MY RELIANCE ON, OR USE OF, THE PRODUCT OR SERVICE. I AUTHORIZE PAYMENT FOR THE AMOUNT AND METHOD INDICATED.</p> <p>Signature X _____</p> <p>Date _____</p>

For Office Use Only

What is the total amount that will be owed? _____ Approved Denied

Payment Amount \$	Description	No. of months	Total to be paid
\$	<input type="checkbox"/> Per Month <input type="checkbox"/> Other:		
\$	<input type="checkbox"/> Per Month <input type="checkbox"/> Other:		
		Total	

Approved by _____ Date _____

Processed by _____ Date _____