Concord Children's Clinic

PAYMENT AGREEMENT FORM

Patient Name: _____ Date_____ Chart #_____
Guarantor's Name: _____

Estimate of services rendered $_____
Amount Paid $_____
Approximate balance remaining $_____

All payment plans require us to have a credit card on file and running the card on the 1st or 15th day of each month. Guarantor must sign a payment agreement form which will be kept in a secure location. The credit card will only be processed for the remaining patient responsibility after the claim has been processed by the patient's insurance. If a credit card declines, we will run it a second time. If it declines again, the parent will be called and will have 5 days to respond to the phone call or the payment plan will be in default and the balance will be due in full. If the balance is not paid in full it will be turned over to our outside collection agency and the family may be discharged from the practice.
I agree to pay Concord Children's Clinic as defined below on the balance of $_____.
Balances between $125-$199 divide over 3 months, $200-$499 divide over 4 months, $500+ divide over 6 months.
I authorize Concord Children's Clinic to charge my credit card in the amount of $_____
○ **On the 1st day of each month**
○ **On 15th day of each month**

Patient's Name _____
Responsible Party _____
Street Address _____
City _____ State _____ Zip Code_____
Phone Number _____ Email address _____
Card Type ○VISA ○Mastercard

_____ _____ _____
Credit Card Number Exp Date 3-digit security code

Cards will automatically be charges as instructed above for the remaining balance.
I understand that if I default on this agreement the payment plan is VOIDED and my account will be turned over to the outside collection agency and my family may be dismissed from the practice if the balance is not paid in full.

_____ _____ _____
Guarantor's Signature Date Approved by