Payment Plan Agreement

Patient Information	
Name	
Date of Birth	
Payment Information	
Cardholder's Name	
Credit Card Type	Visa [ ] Mastercard [ ] Amex [ ] Discover [ ]
Credit Card Number	
CVC (Security Code)	
Expiration Date	
Billing Address	
City, State and Zip	
Phone Number	

Monthly Payment Amount $ _____ to be run on the _____ day of each month.

By signing below, I agree and understand my credit card information will be stored electronically in Clown Pediatric's EMR, eClinicalWorks. I am agreeing to a monthly payment in the amount listed above. Payments will be made until the outstanding balance is paid in full or until one year from the date of this agreement, which is first. One year from this agreement, my credit card information will be automatically deleted from eClinicalWorks. At that time, a new agreement will need to be signed. With the exception of the last four digits, the credit card number above will be redacted from this form before a copy is uploaded into your medical chart.

Payment will be processed on the above day of every month. If this date lands on a Saturday, Sunday or holiday, the payment will be run on the next business day.

_____ _____

Payer's Signature Date