Agreement to Pay for Physician Services

I agree to pay for the services rendered by (*name of physicians or practice*), as indicated below.

Date of Service_____ ___ Payment in full

Date to be paid_____
___ Payment schedule as follows:

Date_____ Amount to be paid_____

Date_____ Amount to be paid_____

Date_____ Amount to be paid_____

____ Payments will be made by cash or check

____ Payments will be made by credit card, which I authorize you to use:

Credit Card:
Visa_____ Exp_____

MasterCard_____ Exp_____

American Express_____ Exp_____

Other_____ Exp_____

Name as appears on card_____

It is understood that if the patient misses payments, without prior notification and agreement, the practice reserves the right to transfer collections to a collection agency.

_____
Name of Patient (print or type)
_____
_____
Patient Address
_____
Phone
_____ _____
Patient Signature Date

Courtesy: Conomikes Associates