

Date: \_\_\_\_\_

RE: Payment Plan

**Balance: \$** \_\_\_\_\_

This is to certify that as per our conversation, \_\_\_\_\_  
(Responsible Party)  
has agreed to the following payment plan on account \_\_\_\_\_ for  
\_\_\_\_\_  
(Patient's Complete Name)

Payment guidelines are as follows:

1. 25% of the balance must be paid to activate the payment plan
2. The balance must be paid in full within two (2) months from the date of the payment arrangement;  
Select monthly payment plan:  
 Every 1<sup>st</sup> of the month       Every 15<sup>th</sup> of the month
3. Failure to adhere to the payment guidelines will result in your account being turned over to the collection agency to pursue all legal means to recover the monies owed to the practice.
4. Well checks can not be scheduled until the balance has been paid in full. Sick visits will be paid following the self pay guidelines until the balance is paid in full.

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

APP Employee: \_\_\_\_\_

Date: \_\_\_\_\_