SPRINGVILLE PEDIATRICS

350 Springville Station Blvd • Springville, AL 35146-6163
Phone: (205) 773-2075 • Fax: (866) 304-9633

It is the policy of Springville Pediatrics LLC to settle all outstanding balances on accounts before a patient is seen in our office; however, we understand that temporary financial situations may affect timely payment of your account. We are willing to offer the following agreement to patients who need to make a number of small payments in order to pay off their account balance.

I, _____, agree to remit payment to Springville Pediatrics LLC and authorize their billing department to process charges to my credit card under the terms outlined below.

Names and account numbers of patients covered under this agreement:

Name _____ Account # _____

Name _____ Account # _____

Name _____ Account # _____

Name _____ Account # _____

Name _____ Account # _____

Current combined balance of all accounts listed above:_____

Total months needed to pay the balance off:_____

Amount to be processed each month:_____

Payment to be processed on the _____day of each month.

(Check one) □ American Express □ Visa □ MasterCard

Credit card # _____ Expiration date: _____

Card Holder Name: _____ Social Security # _____

Billing Address: _____

_____

I understand that if my payment fails to process due to insufficient funds that my account may be sent to a collection agency, and I will be given 30 days to select a new primary care physician. (IF at any given time you are unable to make your scheduled monthly payment, you must call our billing office at least 48 hours PRIOR to payment due date to make other arrangements.)

I understand that no future charges may be added to this plan, as it is not intended to be a revolving charge account. I agree to pay all future visit costs in full at the time of service until the balance discussed in this payment plan agreement is paid in full.

I understand that a copy of this agreement will serve as my reminder and that regular statements will not be mailed for this balance.

Guarantor Signature _____ Date _____

Printed Name _____ Relationship to Patient(s) _____

Employee Signature _____ Date _____