Payment Plan Agreement

First Name _____ Last Name _____ M.I. ____ Date of Birth _____

I authorize Conventions Psychiatry and Counseling to keep the following credit card(s) information on file.

Primary Card Account

_____
Name on credit card (Exactly as printed)

_____
Billing Address

_____
Credit Card Number

_____
Exp. Date CVV2#

_____
Signature Date

Secondary Card Account

_____
Name on credit card (Exactly as printed)

_____
Billing Address

_____
Credit Card Number

_____
Exp. Date CVV2#

_____
Signature Date

I authorize Conventions Psychiatry and Counseling to charge my credit card on file for balances indicated below:

Co-payments
Coinsurance
Deductible
Office Fees- Not limited to: no-show fee, cancellation fee, prescription fee, ect.

I authorize Conventions Psychiatry and Counseling to charge $_____ on the _____ of each month, until the balance of $_____ is cleared. This authorization is valid until I provide you with written cancellation.

_____
Patient/Legal Guardian Signature Date