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 1st of the month** ❑ **Every 15th 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:_____