CAPE COD PEDIATRICS
PAYMENT PLAN AGREEMENT

Patient Name: ___________________________

Patient Account No: ______________________

I acknowledge my current balance of ________ and am requesting that a payment plan be set up to resolve this balance.

I will commit to a payment of $_______ to be sent on the _______________________ of each month.

____ My first payment is enclosed

____ My first payment will be mailed by ____________________.

I understand that I have the option of making debit or credit card payments by phone.

If for any reason I have a problem paying the amount agreed to, I understand that I may reduce the amount as needed but will continue to make a payment on a monthly basis on the date indicated above.

I understand that if I do not follow through with this payment plan, my account will be referred to an outside collection agency. Once that happens my child(ren) will no longer be patients of Cape Cod Pediatrics.

Responsible Party
Signature:____
Print Name: ____

Driver's License State/#_______________________________________

Current Physical Address: ______________________________________
____
____

Current MailingAddress:____

Contact Tel #(s): ____