Midwest Allergy and Asthma Clinic, P.C.

PAYMENT PLAN SIGN OFF FORM

Date: _____ [Place Guarantor Family Label Here]

I, _____ agree to an interest free monthly payment of $_____ to be charged to the credit card I am providing to Midwest Allergy and Asthma Clinic, P.C. until my balance is paid in full.

I understand this payment plan is being established to comply with my financial obligations described in the Midwest Allergy and Asthma Clinic, P.C. Financial Policy. I also agree to contact the Midwest Allergy and Asthma Clinic, P.C. Business Office at 402-397-7407 if I am unable to keep my agreement in good standing each month.

I understand that if additional patient responsibility balances are added to my account after my initial signature, the amount per month may increase or the number of months may increase until the balance is paid in full. I understand that this form is valid unless I cancel the authorization through written notice to the health care provider.

_____ _____

Patient, Guarantor or Authorized Legal Guardian Date

Total Patient Balance Due: _____

Monthly Payment Amount: _____ Business Office Staff Initials: _____

Payment Type (circle one) : VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Flex Plan_____ HSA_____ HRA_____

Payment Date: _____5th _____20th _____Other (Payment will be charged the next Business Day if the 5th or 20th is a weekend or holiday).

Cardholder Name: _____

Cardholder Address: _____

City: _____ State:_____ Zip: _____

Account Number:_____

Expiration Date: _____V-Code: _____

Cardholder Signature: _____ Date:_____

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