**Agreement To Pay for Physician Services**

I agree to pay for the services rendered by (*name of physicians or practice*), as indicated below.

Date of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Payment in full

Date to be paid\_\_\_\_\_\_\_\_\_\_\_   
\_\_\_ Payment schedule as follows:

Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount to be paid\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount to be paid\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount to be paid\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Payments will be made by cash or check

\_\_\_\_ Payments will be made by credit card, which I authorize you to use:

**Credit Card:**

Visa\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp\_\_\_\_\_\_\_

MasterCard\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp\_\_\_\_\_\_\_

American Express\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp\_\_\_\_\_\_\_

Name as appears on card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is understood that if the patient misses’ payments, without prior notification and agreement, the practice reserves the right to transfer collections to a collection agency.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient (print or type)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date