GETTYSBURG FAMILY PRACTICE, INC.

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RECURRING CHARGE PAYMENT PLAN

Date: _____

Patient Name: _____ Account #: _____
Guarantor (if patient under 18 years of age): _____
Email Address for Receipt: _____

_____ I would like to set up a monthly payment plan with Gettysburg Family Practice, Inc. in the amount of $_____. I would like to have my credit card charged on the _____ day of each month. This authorization is good for _____ months. I understand that at the end of that time I will need to set up another payment plan if a balance still exists on my account.

I understand and agree that I am ultimately responsible for the balance on my account. I have read the above payment policy, and agree to all of the terms outlined.

_____	_____	_____
Patient Name	Patient or Guarantor Signature	Date

Office Use Only

Total Account balance as of today's date $_____
Payment Amount - Total Balance divided by 6 (months) $_____
Down payment $_____ (equal to first months payment)
Registration marked Budget - ____

Credit Card #: _____ Expiration Date: _____
Card Verification Digits: _____

REV. 4/20/17