GETTYSBURG FAMILY PRACTICE, INC.
PAYMENT PLAN OPTIONS AGREEMENT FORM

Welcome to Gettysburg Family Practice, where our professional staff are committed to providing you with the highest quality medical services. We realize that it can be difficult to pay at the time of service. Please review the three payment plans we have available and mark √ your selection.

❖ **SELF PAY PAYMENT PLAN**

_____I can pay for the visit in full and receive a 10% discount for today's visit (excludes lab, immunizations, EKG, etc.)

_____I can pay $_____ (50% minimum required) deposit today and the remaining balance within 30 days, however I won't be eligible for the 10% discount.

I fully understand that in addition to the office visit charges today, there may be additional charges for labs, immunizations, etc. I further understand that if there are any additional charges, I will receive a statement with any balance due and agree to pay for all additional charges incurred.

❖ **RECURRING CREDIT CARD CHARGE PAYMENT PLAN**

_____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.

Credit Card Number: _____ Exp. Date: _____

❖ **MONTHLY CHECK PAYMENT PLAN**

_____I would like to set up a monthly payment plan with Gettysburg Family Practice, Inc. in the amount of $_____. I am aware that payments are expected by the last day of each month. If payment is not received, and there is no phone call made in regards to the account in question, it will automatically be sent to a collection agency and I will be dismissed from the practice. If no down payment is made today, I understand that the first payment on the account will be due by the end of the current month (_____). If the first payment is not received in a timely manner, the account will be considered past due.

AUTHORIZATION AND RELEASE

I have read and fully understand the policies as outlined above. I understand and agree that I am ultimately responsible for the balance on my account and agree to all of the terms that are outlined for the plan I have chosen. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all costs associated with the collections process.

By signing this form, I understand I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility.

_____	_____	_____
Patient Name	DOB of Patient	Account #
_____	_____	
Patient or Guarantor Signature	Date	
_____	_____	
GFP Representative Signature	Date	

REV. 7/23/19