Financial Policies

Patient Name:
Patient Address:
Patient City, State, Zip:
Account # :

Date:

This document is an agreement for an approved payment plan based upon policy set by Plastic Surgical Arts.

The patient listed above will agree to this payment plan as prescribed below for the patient's account balance. Should the patient deviate from the prescribed payment plan at any time (including but not limited to: missed payments, late payments, declined payments, or payments not made in full), Plastic Surgical Arts reserves the right to charge interest, penalties, or consider delinquency at any time. For this reason Plastic Surgical Arts requires the patient to file credit card information for automatic payments to be made as outlined by the payment plan.

Plastic Surgical Arts is confined to deduct only the payment amount as prescribed below using the patient's credit card information, unless otherwise informed by notification from the patient.

The patient agrees to pay Plastic Surgical Arts $________ per month starting ______________. This amount will be collected on the ____________________of each month until the patient balance is $0.00.

Account Type: Visa MasterCard AMEX Discover

Cardholder Name: ____

Credit Card Number:

Expiration Date:

SIGNATURE: ____ DATE:

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.