

PEDIATRIC PRACTICES OF NEPA PAYMENT PLAN AGREEMENT

This agreement is between you and Pediatric Practices of NEPA for the sole purpose of payments on your account # _____, in the name of: _____.
By signing this financial agreement, you are bound to pay the disclosed balance in full as set forth in the following payment plan terms. IF at any given time you are unable to make the payment as set forth, you must call our billing office at 570-253-9240 within 48 hours PRIOR to payment due date. Should a payment be processed on due date and funds are not available, you will be responsible for any fees unpaid, including returned check charges of \$25.00 for each item returned, and may jeopardize any future payment plan options with Pediatric Practices of NEPA. Any account balance is due within 30 days of billing. If payment arrangement are made to avoid collection activity, the first delinquent payment of this agreement justifies further collection activity, which may be enforced by our billing department.

I, _____ hereby give permission to Pediatric Practices of NEPA permission to charge my credit card (circle one) master card , visa , debit ID # _____ expiration _____ Card Holder Name: _____ Social Security # _____. The balance to be paid on is \$ _____, with the following payment dates and amounts to be processed by our billing department.

Starting Balance\$ _____

Amount of Payment Date to be charged Balance due Initial of Processor

Date: _____ Signature of Card holder: _____

Date: _____ Signature of Account: _____

Date: _____ Signature of Pediatric Practices NEPA Agent: _____