ARLINGTON EYE PHYSICIANS

Patient Payment Plan

I, _____, the patient, (Account # _____) understand that I am agreeing to the following payment plan between myself and Arlington Eye Physicians. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe listed below. All unpaid balances 30 days or older will be considered for third party collections.

Current patient account balance is $_____ as of (date) _____.

The monthly payment will be $_____ and payment will be due on the 16th of each month.

Payment Options:

Initials

I authorize Arlington Eye Physicians, LLC to keep my signature on file and to charge my credit card account monthly for each payment. I understand that this form is valid until the account balance has been paid in full, unless I cancel the authorization through written notice to Arlington Eye Physicians, LLC's office.

(Your credit card information is kept highly confidential)

Type of Card (Circle): **Mastercard** **Visa** **American Express** **Discover**

Account #: _____ Expiration Date: _____

V-Code (3-digit security code): _____ Billing Zip Code: _____

Patient or Guarantor Printed Name:_____

Patient or Guarantor Signature _____

Date:_____