ENT Associates of Worcester

Sinus • Hearing • Allergy

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Payment Plan Agreement

Last name **First name** **DOB**

Address **MRN**

Thank you for choosing ENT Associates of Worcester Inc. as your health care provider. We are committed to the success of your treatment and care. Payment for services provided is a part of the physician-patient relationship with your doctor. Per the financial policy of the practice, patients and guarantors are responsible for making the necessary payments toward the services they receive. With the changing environment in health care, more responsibility for payment is being placed on the patient in the form of copays, high deductibles and out-of-pocket costs.

At the sole discretion of the practice, we are offering you this opportunity to set up a mutually feasible payment plan for treatment you will receive or have already received. This payment plan agreement authorizes us to obtain and keep your credit or debit card information on file as a convenient method of payment for the services provided. Your credit or debit card will be charged automatically for the negotiated amount, on the mutually agreed date. Continuous periodic installments are required for the duration of time an outstanding balance exists on your account.

In consideration of the practice accepting installment payments toward your balance, you are expected to:

1. Make the payments as agreed upon without default.
2. Make payments until the outstanding balance in your account is zero dollars ($0).

For your convenience, our practice offers this payment plan with no finance or interest charges. If we receive the periodic payments set forth in this agreement, our practice shall not pursue any additional collection actions on your account. However, any default on the terms of this payment agreement shall render the entire outstanding balance due immediately, and payment in full will be expected. A default on the terms of this agreement will result in our practice pursuing collection efforts. If you have insurance coverage, our practice will submit all claims to your insurance for reimbursement.

By signing this agreement, you waive the statute of limitations as a defense to any lawsuit for the collection of any amounts due.

This payment agreement shall be considered binding after the responsible party has signed and dated the agreement and payment authorization overleaf.

I agree to the terms of this Payment Plan Agreement:

Patient signature: _____ **Date:** _____

Patient name: _____

CARDHOLDER INFORMATION

Cardholder signature: _____ **Date:** _____

Cardholder name: _____

Credit/Debit Card Pre-Authorization Form

I authorize ENT Associates of Worcester Inc. to charge my credit card for the following outstanding balances using the payment method selected below:

☐ Balance remaining after claim(s) is (are) processed, not to exceed $ _____ for:

- ☐ This visit only
- ☐ All visits this calendar year
- ☐ All visits from _____ to _____
- ☐ Perpetual

☐ Recurring charges of $ _____ to be assessed every _____ (frequency) until the balance on my account is paid off.

PAYMENT INFORMATION

☐ Visa® ☐ American Express® ☐ MasterCard® ☐ Discover Card® ☐ Other: _____

Patient name: _____

Cardholder name: _____

Cardholder address: _____

City: _____ **State:** _____ **Zip:** _____

Credit card number: _____

Exp. date: _____ **CVV/CVC/CVC2 code:** _____

Cardholder signature: _____ **Date:** _____

Cardholder name: _____

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