GOOD HEALTH
PHYSICAL THERAPY & WELLNESS

Payment Plan Agreement

_____ (Patient) owes $_____ to Good Health Physical Therapy & Wellness (Clinic) for physical therapy services provided.

Patient has made a one time payment on account of $_____ bringing the balance due to $_____.

In consideration for Clinic agreeing to wait for payment, Patient hereby agrees to pay $_____ per month on the _____ of each month until balance is paid in full. Patient agrees that any further balances that accrue on his/her account will be added to the amount owed in the payment plan.

If Patient fails to make a payment when due, the entire balance may be turned over to collections at Clinic's option. If the account is turned over to collections Patient further agrees to pay all reasonable costs associated with the collection of this debt. This includes but is not limited to collections service fees, attorney fees and all court costs and additional legal fees associated with the recovery of the amount owed.

_____ _____

Patient Signature Date

_____ _____

Clinic Representative Signature Date

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ◯ MasterCard ◯ VISA ◯ Discover ◯ AMEX Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
CVV Code: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card for account balances for services rendered and any associated fees. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date