Payment Plan Agreement

Patient Name: _____

Date of Birth: _____

1. Balance and Payment Terms

- **Total Balance Due:** $_____

- **Payment Method:** ☐ Debit/Credit Card ☐ Card on file ☐ Check ☐ Other: _____

- **Payment Schedule:** Patient agrees to pay the above balance in three (3) equal monthly installments of $_____ each.

- **Installment Due Dates:** on or around

1. Payment 1 Due: ___, ___, ____
2. Payment 2 Due: ___, ___, ____
3. Payment 3 Due: ___, ___, ____

2. Disclosures

- This Agreement does not represent financing or a loan. It is simply a payment arrangement to satisfy your balance.

- Payments must be made on or before the due date.

- If full payment is not made according to this Agreement, Intentional Dermatology and Health reserves the right to pursue collection remedies.

- This Agreement does not alter the patient's responsibility to pay for services rendered.

3. Authorization

By signing below, I agree to the terms of this Payment Plan Agreement and authorize Intentional Dermatology and Health to collect payments as outlined above.

Patient Signature

I understand and agree to the terms of this payment plan:

Patient Signature: _____ Date: ___, ___, ____

Printed Name: _____

Provider / Staff Signature

Staff Signature: _____ Date: ___, ___, ____