Center for Pediatric Medicine
107 Newtown Rd. Suite 1D
Danbury, CT 06810
(203) 790-0822

Payment Plan Agreement

Patient Name:
Responsible Party Name:
Account Number
Balance Owed:

I________________________________ understand that I am agreeing to the following payment plan between myself and Center for Pediatric Medicine. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe agreed upon below. All unpaid balances 15 days past the agreed upon payment date will be forwarded to a third-party collection agency.

My current balance is $__________, I agree to pay $__________ on the ________ day of every month (not to extend past 12 months) for ________ months to be automatically withdrawn from the card I have on file with CPM.

I hereby authorize Center for Pediatric Medicine to deduct the payment amount monthly on the day indicated above from my debit/credit card account

I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount which will be added to my payment plan balance.

Any questions or concerns that I may have had concerning this agreement were answered or discussed with one of the staff members at Center for Pediatric Medicine. If this agreement needs to be revised at any time, I will contact the Billing Manager, Tami Lindo, at 203-798-7991 ext. 101 to discuss further options. Patient's (or Guarantor's) Initials _________

____
Patient or Guarantor Printed Name

____
Patient or Guarantor Signature

____
Date

____
Witness: Staff of CPM Signature