Dougal, McClellan, Sullivan & Ethington Eye Associates

Payment Plan Agreement

I, _____, agree **OR** I, _____, agree on behalf of

Name Guarantor's Name

_____, [Account Number:] to enter into a payment plan agreement with

Patient Name

Dougal, McClellan, Sullivan & Ethington Eye Associates within the parameters listed as follows:

Please **Mark** the applicable Payment Option

☐ I agree to monthly payments of $_____for the current balance of $_____, being automatically deducted from the payment information listed below, on the _____ Day of each month until _____ of **20 ___**.

Name on the card: _____

Credit Card Type: **VS MC DISC AMEX** (Circle Payment type)

Card Number: _____-_____-_____-_____

CVC (3 or 4 digit security number): _____

Expiration Date: _____/_____

MM YY

OR

☐ I agree to send in a payment of $_____ or call in this payment every month after receiving the monthly statements until _____ of **20**___.

Minimum Monthly Payment Scale (Based on Amount of Outstanding Balance)

$5—$99	**$10 Monthly**
$100—$250	**$25 Monthly**
$251—$500	**$50 Monthly**
$501 and Above	**$100 Monthly**

I understand, if there are insurance claim payments pending from the insurance company, that this balance may change. I understand if the balance extends two months beyond the agreed time frame that a monthly APR of 2% will accrue on the balance remaining. I understand that in the event that I am unable to continue this agreement or have questions, I will immediately contact the Billing Dept at (773) 775-0811, Option 7 in order to avoid any collection procedures.

_____ _____

Guarantor Signature (If applicable) Date

_____ _____

Patient Signature Date

_____OFFICE USE ONLY_____

Agreement Processed on: _____ Initials of Processor: _____

Copy of Payment Plan Agreement :

Given to Patient: ☐

Kept on File only: Patient declined copy ☐