

# Northlake Obstetrics & Gynecology, P.A.

## MONTHLY PAYMENT AGREEMENT

**Patient Name:** \_\_\_\_\_ **Account No.:** \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Current Balance or Projected Balance:** \$ \_\_\_\_\_

**Credit Card Payment Plan Option:** I authorize Northlake OB/GYN to debit the credit card listed below for the amount(s) and date(s) listed. I understand that Northlake OB/GYN will keep my credit card information confidential and the information will only be used for the purposes of this payment plan. If I do not pay for services rendered to the patient, and the account is turned over for collection, I agree to pay all costs, fees and expenses incurred by Northlake OB/GYN in collection or attempting to collect any amount due under this agreement.

Date: ___/___/___	Amount to be debited: \$ _____	Pt Initial: _____
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Date: ___/___/___	Amount to be debited: \$ _____	Pt Initial: _____
Date: ___/___/___	Amount to be debited: \$ _____	Pt Initial: _____

If for any reason my credit card is denied and I do not meet my agreed upon financial obligation for services rendered and my account is turned over to collection, I agree to pay all costs, fees and expenses incurred by Northlake OB/GYN in collecting or attempting to collect any amount due under this agreement.

**Type of Credit Card:** \_\_\_\_\_

**Name on Credit Card:** \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_

**Exp. Date:** \_\_\_\_\_ **Three digit code on back of the card:** \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Billing Address of Credit Card:** \_\_\_\_\_

**Email to:** [jackieo@northlakeobgyn.com](mailto:jackieo@northlakeobgyn.com)