UNION PHYSICAL THERAPY

Payment Plan Agreement

Patient's Name: _____ Date of Birth: _____

Previous Name (if applicable): _____

To cover the cost of my care at Union Physical Therapy I agree to the following:

My balance must be paid based on the schedule above or my account will be referred to Puget Sound Collections

Balance Amount	**Payment Timeline**
$0-$1000	1 Month from completion of care
$1000-$1500	3 Months from completion of care
$1500 or more	6 Months from completion of care

I agree to release credit card information to Union Physical Therapy to keep on file in a secure virtual vault and be processed as agreed in the above outline. ***Name on card:*** _____

Credit card number: _____ ***EXP date:*** _____ ***CVV:*** _____

_____ _____

Signature: Date:

_____ _____

Final Balance: Last Payment Expected

THIS AGREEMENT DOES NOT EXPIRE

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