UNION PHYSICAL THERAPY

# Payment Plan Agreement

| |
|---|
| Patient's Name: _____ Date of Birth:_____ |
| Previous Name (if applicable): _____ |

In order to continue my care at Union Physical Therapy I agree to the following: I agree to pay $40 each visit and I agree to make a minimum monthly payment of $**100.00** towards my account balance with Union Physical Therapy. If there is a balance remaining at the completion of my visits, my balance must be paid based on the schedule below 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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