

**Patient Payment Plan**

Date: \_\_\_\_\_\_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I agree to make Weekly/Biweekly/Monthly payment(s) in the amount of $\_\_\_\_\_ until my balance is paid in full.

\_\_\_\_ I agree and authorize Crosspointe Family Services to debit my credit/debit card for the amount of $\_\_\_\_\_\_\_\_\_ on a monthly basis until my balance is paid in full. The monthly payment amount will be debited from my account on the \_\_\_\_ day of each month.

\_\_\_ I agree to make all payments as agreed. If I fail to make payments as agreed, I agree to pay for all costs of collection.

**Card Information:**

\_\_\_ Visa \_\_\_ MasterCard

Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code:\_\_\_\_\_\_\_ Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_