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Confidential Care
Payment Plan Agreement

For office to complete:
Client Name: _____
DOS: _____
Outstanding Balance: _____
#1: Auto-Pay? __Yes __No
#2: Scheduled Pay? __Yes __No

Client Name: _____

This document is to act as a set agreement for an approved payment plan based upon policy set by Confidential Care.

The client listed above will agree to this payment plan as prescribed below for the client's outstanding account balance. Should the client deviate from the prescribed payment plan at any time (including but not limited to: missed payments, late payments, declined payments, or payments not made in full according to the prescribed agreement) Confidential Care reserves the right to charge interest, penalties, or consider delinquency at any time. For this reason Confidential Care requires the patient to file credit card information for payments to be made as outlined by the payment plan. We assure you that your information is respected with the highest level of confidentiality, is not shared with any other source, and is securely protected separately from your therapy file.

Confidential Care is confined to deduct only the minimum payment amount as prescribed below using the client's credit card information, unless otherwise informed by notification from the client.

I, _____ authorize Confidential Care, LLC to keep my signature on file and charge my credit card account as indicated below for payment security.

Check one of the following options:

Option # 1: Automatic monthly payment plan
[ ] The client agrees to pay Confidential Care $_____ per month starting _____. This amount will be collected on the fifteenth of each month until the client balance is $0.00.
(Not to exceed 2 consecutive months/60 days unless approved by the billing department at Confidential Care)

Option #2: Scheduled payment plan
[ ] The client agrees to pay Confidential Care according to the scheduled payment plan:

Date: _____ Amount to be paid: _____

Date: _____ Amount to be paid: _____

Date: _____ Amount to be paid: _____
(Not to exceed 2 consecutive months/60 days unless approved by the billing department at Confidential Care)

Please sign and return this original document along with the payment information form (see attached). Signature of this document denotes that all parties agreed to the terms of this arrangement.

Client Name: _____ (print)

Client Signature: _____ Date: _____

Confidential Care: _____ Date: _____

Pre-Authorized Credit Card Payment Form

CLIENT NAME: _____

CARDHOLDER NAME: _____

Account Number: _____

Expiration Date: _____/_____ Security Code: _____ Zip Code where bill is sent: _____

Signature: _____ Date: _____

For billing department use only: