HMI FOOT AND ANKLE

Podiatry Practice Payment Plan Agreement

Patient Name: _____ **Account Number :** _____ **Date:** _____

This Payment Plan Agreement ("Agreement") is made between HMI Foot and Ankle Group SC ("Provider") and the undersigned patient ("Patient"). The purpose of this Agreement is to outline the terms and conditions of the payment plan for any outstanding balances owed by the Patient.

1. Payment Plan Details

- **Total Balance Due:** $_____
- **Initial Payment:** $_____ (Due upon signing this Agreement)
- **Monthly Payment Amount:** $_____ (To be charged on the ____ day of each month)
- **Credit Card Number:** _____ Expiration: _____ CVD: _____

2. Credit Card Requirement

To participate in the payment plan, the Patient agrees to provide a valid credit card on file with the Provider. The Patient authorizes the Provider to charge the agreed monthly payment to the provided credit card. The Patient further agrees to keep the credit card information up to date with the Provider.

3. Declined Payment

If a credit card payment is declined, the Provider will attempt to contact the Patient for updated payment information. If payment is not received within 5 business days, a $25 fee will be added to the Patient's outstanding balance. The Patient will be responsible for this additional fee, and failure to provide updated payment details may result in suspension of services or additional action to collect the debt.

4. Changes to Payment Plan

If the Patient wishes to modify the terms of the payment plan (e.g., change the monthly payment amount), they must submit a request in writing which may be subject to approval by the Provider. Any agreed-upon changes will be documented in an updated payment plan agreement.

5. Agreement Duration

This Agreement will remain in effect until the balance is paid in full. The Patient agrees to continue making payments as outlined in this Agreement until the outstanding balance is cleared.

6. Cancellation of Payment Plan

The Provider reserves the right to cancel the payment plan if the Patient misses two consecutive payments or fails to update payment information in a timely manner after a declined payment. Upon cancellation, the remaining balance will become due immediately, and the Provider may take further steps to collect the debt.

7. Consent to Payment Charges

By signing this Agreement, the Patient consents to the automatic charges for the monthly payments on the credit card provided and acknowledges the $25 fee for any declined payments.

Patient or Legal Guardian Signature: _____ Date: _____

Legal Guardian Name (if applicable): _____

Relationship to Patient: _____ Witness Signature: _____

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