Patient Payment Plan

Patient Name:______________________________ Current Balance:$____________________________

Date of Birth:______________________________ Balance Pending Insurance:$__________________

Last 4 of SSN ______________________________ No. of Months to be Paid (2-6):________________

Date of Automatic Payment (1st or 15th):_________ Monthly Payment:$__________________________

We understand there may be hardships and are happy to work with you to resolve your balance by setting up a paymemt plan that allows t**he current account balance (along with any newly accrued patient balances) to be divided into a maximum of six (6) equal, monthly payments.**

I understand I am entering into a payment plan with North Fulton Internal Medicine Group, PC (NFIMG). I understand all balances must be paid within the agreed upon timeframe and any missed, declined, or unpaid balances greater than 30 days will be considered for third party collections and subject to an additional $25 late fee per month.

I understand that if claims are still pending with insurance at this time, I may owe an additional amount to the current balance. I understand the monthly payment may be increased to include the new amount due over a maximum period no more than 6 months.

I authorize NFIMG and its affiliates to automatically process a payment as indicated above to the following debit/credit card:

Type of Card (Circle): Mastercard Visa American Express Discover

Card Number: ____ Exp. Date: ____________

Security Code/CVV: _________ Billing Zip code: ___________________

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Patient or Guarantor Printed Name Patient or Guarantor Signature

____

Date NFIMG Signature