Neurology Clinic

Patient Payment Plan Consent Form

Last Name **First Name** **DOB**

Address **Patient ID**

Payment Plan Terms and Conditions

Thank you for choosing The Neurology Clinic P.C. as your healthcare provider. We are committed to ensuring that you receive the care you need while making payment arrangements that are manageable for you. The following are the terms and conditions for enrolling in the patient payment plan:

1. Total Amount Due: $_____ Initial Payment: $_____ (Due on: _____/_____/_____)

2. Payment Frequency: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: _____

3. Payment Amount: $_____

Listed below are our payment plan options:

Balance	Minimum Payment Amount
$300 or under	$75 per month, not to exceed four (4) monthly installments
$301 - $600	$100 per month, not to exceed six (6) monthly installments
$601 - $1,200	$150 per month, not to exceed eight (8) monthly installments
$1,201 - $1,500	$150 per month, not to exceed ten (10) monthly installments
$1,500 or above	$200 per month, not to exceed twelve (12) monthly installments

Acknowledgement of Financial Responsibility

I understand and agree that I am financially responsible for the payment of my medical services. I acknowledge that the payment plan has been established to help me manage the cost of my care. By signing this consent form, I agree to the following:

1. I agree to make all scheduled payments as outlined in the payment plan.
2. I understand that failure to make payments on time may result in the cancellation of the payment plan and the full balance becoming immediately due.
3. I agree to notify the provider of any changes in my financial situation that may impact my ability to make payments on time.
4. I understand that this payment plan does not alter or reduce the total amount owed.

Termination of Payment Plan

This payment plan may be terminated under the following circumstances:

- Failure to make payments as agreed.
- Request by the patient or provider to terminate the agreement.
- Full payment of the outstanding balance.

Authorization

I authorize the provider to use the payment method(s) indicated below to automatically deduct scheduled payments for the duration of the payment plan:

Payment Method: ☐ Credit Card Number: _____Expiration Date (MM/YYYY): _____ /_____ Credit Card Security Code: _____

☐ Bank Account Number: _____Routing Number: _____

Patient Agreement

By signing this form, I acknowledge that I have read, understood, and agree to the terms of the payment plan outlined above. I also acknowledge that I have been given the opportunity to ask questions and that all of my questions have been answered to my satisfaction.

Patient Signature: _____Date: _____/_____/_____

Provider/Clinic Representative Signature: _____ Date: _____/_____/_____

Clinic Contact Information: If you have any questions or need to make changes to your payment plan, please call (901) 747-1111 or email blyons@neuroclinic.org.

This form is legally binding once signed and will remain in effect until the payment plan is fulfilled or terminated as outlined above.