128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

Patient Payment Plan Contract

We have noticed a significant increase in the number of patients not fulfilling their obligation to pay their deductible, co-insurance, co-payment and non covered services. We have implemented a payment plan policy to help solve this growing problem.

I understand that I am enrolling in a payment plan to fulfill the balance of my account. I will make payments to Milltown Family Physicians, Inc. as described below.

Payment will be made by (cash/ check/ credit card)
Please circle one

Payment amount promised $ _____ (weekly, bi- weekly, or monthly)
Please circle one

Date of First Payment: _____

Patient(s) Name: _____ **Date:** _____

Patient(s) Signature: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: ( ) _____-_____

I authorize Milltown Family Physicians, Inc. to charge my credit card for the balance of charges not paid by my insurance plan including deductibles and co-insurances for all patient accounts listed.

I understand this amount will be charged as specified above until the account has reached a zero balance.

I understand this form is valid for one (1) year unless I cancel the authorization through written notice to Milltown Family Physicians, Inc.

Name on Credit Card: _____

Credit Card Number: _____ **Expiration Date:** _____

_____ _____
Cardholder Signature **Date**

Rev. 2/2014