Women's Health Care Specialists

PAYMENT PLAN AGREEMENT

Patient Name: ______________________________________**Account No**.: _______________

Patient DOB: ______________________________________ **Phone #**: __________________

Current Balance or Projected Balance: $ __________________________

Credit Card Payment Plan Option: I authorize WHCS to debit the credit card listed below for the amount(s) and date(s) listed. I understand that WHCS will keep my credit card information confidential and the information will only be used for the purposes of this payment plan. If I do not pay for services rendered to the patient, and the account is turned over for collection, I agree to pay all costs, fees and expenses incurred by WHCS in collection or attempting to collect any amount due under this agreement.

Date:___/___/___ Amount to be debited: $________ Pt Initial:________

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Date:___/___/___ Amount to be debited: $________ Pt Initial:________

Date:___/___/___ Amount to be debited: $________ Pt Initial:________

If for any reason my credit card is denied and I do not meet my agreed upon financial obligation for services rendered and my account is turned over to collection, I agree to pay all costs, fees and expenses incurred by WHCS in collecting or attempting to collect any amount due under this agreement.

Type of Credit Card: _________________________________

Name on Credit Card:____

Credit Card Number:____

Exp. Date:___________ **Three digit code on back of the card**:_________

Authorized Signature:_______________________________________**Date**:_______________

Billing Address of Credit Card: ____

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Email to: services@whcsobgyn.com