MC without SECONDARY INSURANCE
PAYMENT AGREEMENT

I, ____, agree to pay **Delta Medical, PA** (d/b/a Delta Medical Clinic) all amounts determined by Medicare as my **Co-insurance, Annual Deductible or "Patient Responsibility":**

This agreement takes precedence over any other statements pertaining to my financial responsibility to Delta Medical, PA. Delta Medical, PA is hereby granted implied and explicit authority to debit my Checking/Savings or Credit Card account in the event I fail to make payments 30 days after receipt of payment notice. Finance charge of **15%** annual **APR** will begin to accrue on outstanding balances after the initial 30 Days grace period. Personal checks returned due to insufficient funds will incur returned check fees and may require cash payment as the only condition for settlement of bill. At least one of the payment options provided in the next section must be provided.

Method of Payment:

Bank Account(s)*: ❑Savings ❑Checking *See information above

____
Print Names as written on a Check

Bank Account #:________________________________ Bank Routing #: ____________________________

Bank Name:________________________________ Bank Telephone ____________________

____
Bank Address City State Zip

Credit Card (Check one):

______ Visa®

______ MasterCard®

Name (as it appears on the card):____

Three Digit Security Code on the Back of the Card (last three):________________

Credit Card Number: ________________________ **Expiration Date**:___________ __

I authorize **Delta Medical Clinic** to keep my signature on file and to charge my payments to the credit card selected above or my Checking/Savings Account.

I authorize Delta Medical Clinic, a division of Delta Medical, P.A., to initiate entries to my Checking/Savings account or Credit Card. This authorization will remain in effect until I notify Delta Medial Clinic in writing to cancel it. I can stop payment on any scheduled charge by contacting the clinic to request cancellation of the transaction before 1PM CST on the business day prior to the day on which the payment is scheduled to occur.

Signing this document serves as the only notification of pending charges on my Checking/Savings Account or Credit Card. I will not receive any additional warnings, prior notifications or telephone calls from any Delta Medical Clinic personnel. Unavailability of funds in my account at the time of scheduled transaction will result in "insufficient fund" fees to be applied to my account with Delta Medical Clinic. Delta Medical Clinic is not responsible for any bank charges resulting from effecting this transaction.

____
Signature of Responsible Party/Cardholder Date

____
Print Name of Responsible Party/Cardholder Print Patient Name(s)

____
Address City State Zip

(____)____________________________________
Phone Number