PAYMENT PLAN AGREEMENT

I, _____, agree to remit the following payments to **Delta Medical Clinic:**

	AMOUNT	PAYMENT DATE	Check #
Pmt 1			
Pmt 2			
Pmt 3			
Pmt 4			
Pmt 5			

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.

Please provide current Credit Card or Checking Account information and sign appropriate section.

Credit Card:

Card #: _____ Expiration date: _____ Security Code: _____

Print Name as it appears on the Credit Card: _____

Signature: _____ Date_____

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

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: _____ Date_____