



516-750-9750 fax: 516-750-9751

Patient Plan

Name: _____ Patient Name: _____

Address: _____ Apt. # _____ SS# _____

City: _____ State: _____ Zip: _____ Birth date: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Drivers License # _____ State: _____

The undersigned agrees to pay to **Professional Payment Plans, Inc.** (hereafter ProPay), the amounts stated below and any additional charges in accordance with the terms and conditions contained herein and attached Schedule A.

of Months: _____ Start Date: _____ IAP fee: **\$45.**

MPF fee: **\$4 per month** Doctor: _____ Payment Date: 1st _____ 15th _____
(please check one)

Monthly Payment: _____ Total Amount Due: _____

I, _____ agree to the above and attached Schedule A and authorize my

bank to make payment from my **Checking account #** _____

Bank: _____

Signature: _____ **Date:** _____

Schedule A

A. Acknowledgement : I hereby acknowledge that I am over 18 years of age and I have read and understand this agreement, and all of the information provided is complete and accurate. I agree to pay the Total Amount Due stated above by authorizing ProPay to withdraw from my checking account the monthly payment and any other charge (as defined in Paragraph B) every month during the term of this agreement on or after the payment date by automatic debit (EFT) or any other method. I also agree to notify ProPay immediately in writing of any changes in my personal information provided. I further acknowledge that my obligation to make the agreed upon payments to ProPay is unconditional and any claims that I may have relating to the treatment and medical care given by the Healthcare Provider listed above are not a setoff or a defense to my obligations to make all payments due and owing to ProPay.

collection fee if it is necessary for ProPay to visit my home or work-place to collect or attempt to collect any payment. I agree to pay all reasonable attorney’s fees, legal costs and other collection expenses necessary to collect on my debt.

B. Other Charges: I agree to pay the one time only Initial Application Processing fee (IAP) upon execution hereof. I agree to pay a Monthly Processing fee (MPF) for each month of the plan. I agree to pay a late charge of not more than the greater of \$5 or 10% of my delinquent monthly payment if my monthly payment is more than 7 days late. I agree to pay NSF fee of \$25 for each instance where funds in my checking account are insufficient to pay all amounts due. I agree to pay an in home

C. Acceleration : I agree that if I remain in default of any monthly payment beyond 30 days, the balance of my total payment still due plus any other charges will immediately become due in full, and I hereby authorize ProPay to deduct the full amount from my checking account.

D. Interest: I agree that there will be no interest charges as long as I am not delinquent. If I am delinquent of any payment 30 days or more, I agree to pay interest on the total balance due at the highest rate of interest allowed by law.

E. Authorization: I hereby agree to allow ProPay to communicate with any person or company, including my employer, and any credit agency, about my debt, credit, reliability, or any other relevant information.

Patient Information Form

Landlord or Mortgage Co (if own home): _____

Address: _____

Contact Name: _____ Phone # _____

Yrs. at Current Address: _____ Previous Address: _____

Employer: _____

Address: _____

Contact Name: _____ Phone # _____

Position: _____ Salary: _____ Yrs. of Employ: _____

If no employer, explain source of income: _____

References (at least three with one immediate relative)

Name: _____ Phone # _____

Address: _____ Relationship: _____

Name: _____ Phone # _____

Address: _____ Relationship: _____

Name: _____ Phone # _____

Address: _____ Relationship: _____