DUPAGE PEDIATRICS, LTD.
PAYMENT PLAN FORM

Thank you for choosing DuPage Pediatrics as your health care provider. Per the financial policy of the practice, patients and guarantors are responsible for making the necessary payments toward the services they receive. With the changing environment in health care, more responsibility for payment is being placed on the patient in the form of copays, high deductibles and out-of-pocket costs.

DuPage Pediatrics is offering you this opportunity to set up a payment plan for treatment already received. This payment plan agreement authorizes us to obtain and keep your credit or debit card information on file as a convenient method of payment for the services provided. Your credit or debit card will be charged automatically for the amount, on the agreed date. Payments are required for the duration of time an outstanding balance exists on your account.

In consideration of the practice accepting payments toward your balance, you are expected to:

1. Make the payments as agreed upon without default
2. Make payments until the outstanding balance in your account is zero dollars ($0).

For your convenience, our practice offers this payment plan with no finance or interest charges. We understand that unforeseen circumstances can arise, and we encourage you to contact us immediately if you are experiencing financial difficulties that prevent you from making a scheduled payment. We will try make a mutually agreed arrangement for that payment. However, any default on the terms of this payment agreement shall render the entire outstanding balance due immediately, and if payment is not received services will be terminated.

I agree to the terms of this Payment Plan Agreement:

Parent/Guarantor Signature:_____**Date:**_____

Parent/Guarantor Name:_____**Account #:**_____
(please print legibly)

Primary Phone Number:_____
(please print legibly)

Patients Name:_____**Date of Birth:**_____
(please print legibly)

Patients Name:_____**Date of Birth:**_____
(please print legibly)

Patients Name:_____**Date of Birth:**_____
(please print legibly)

Patients Name:_____**Date of Birth:**_____
(please print legibly)

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Credit/Debit Card Pre-Authorization Form

Credit Card/Cardholder Information

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I authorize DuPage Pediatrics, Ltd. to charge my credit/debit card as listed below.

Amount to be charged: $ _____

Frequency of Charge: ☐Weekly ☐bi-monthly(every 14 days) ☐Monthly

Processing Date Each Month(please choose a numeric date) _____

The credit card will be charged at 1:00am on the date chosen in the event the payment does not process on that date our system will automatically retry processing the payment for 10 consecutive days.