

Patient Name(s): _____

Partial Payment Options - 2010

- We will accept partial payments by either post-dated checks or credit card on file.
- Payments may be spread over a three-month period for the following amounts:

	<u>Fee</u>	<u>Monthly Payment</u>
1 Child	\$115.00	(\$38.33 per month for 3 months)
2 Children	\$220.00	(\$73.33 per month for 3 months)
3 or More Children	\$250.00	(\$83.33 per month for 3 months)

- All partial payments must be dated for either the **1st or 15th** of the month
- Payments must be arranged by April 1, 2010
- Please contact the office manager to make other financial arrangements

Post-dated Checks:

Total Due: _____ Number of Payments: _____ Payment Amounts: _____
Payment Start Date _____ (1st or 15th) Payment End Date: _____ (1st or 15th)

Signature: _____ Date: _____

Print Name: _____

Credit Card on File:

I, _____ authorize Pediatric Associates of Austin, P.A. to initiate credit card charge/s. I understand the funds will be billed to my charge account within the 24-48 hours of the due date. This is valid for credit card charges for the amount(s) as stated below. I agree to notify Pediatric Associates of Austin, P.A. if my credit card account expires 10 days prior to the due date.

Total Due: _____ Number of Payments: _____ Payment Amounts: _____
Payment Start Date _____ (1st or 15th) Payment End Date: _____ (1st or 15th)

Credit Card # _____ Exp. ____/____/____ Zip Code: _____

Visa, MasterCard, Discover

Signature: _____ Date: _____

Print Name: _____

Please include your email address below if you wish to receive a **credit card** receipt via email.

Please submit this Partial Payment Option Form with the Value-Added Services Agreement so we can ensure your account is posted properly. Thank you.