Pediatric Associates of Austin, P.A.
Partial Payment Options ~ 2023

Patient Name(s): _____

- 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:

	Fee	Monthly Payment
1 Child	$130.00	($43.33 per month for 3 months)
2 Children	$235.00	($78.33 per month for 3 months)
3 or More Children	$265.00	($88.33 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, 2023**
- 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:** **To make a payment by phone, call 512-814-1600**

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)

Signature: _____ Date: _____

Print Name: _____ Email:_____

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

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Credit Card #_____ Exp. _____/_____ CVC Code _____

Zip Code: _____ ___Visa, ___ MasterCard, ___ Discover, ___ American Express

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