Synergique Healing, PA

Behavioral Health & Functional Medicine

Payment Plan Agreement

Today's Date: _____

I, _____ , agree to pay Synergique Healing, PA, for my outstanding balance of $_____ .

Date of Payment	Amount to Pay

This document is to act as a set agreement for an approved payment plan based upon policy set by Synergique Healing, PA. The patient listed above will agree to this payment plan as prescribed below for the patient's outstanding account balance.

_____Should the patient deviate from the agreed payment plan at any time **(including but not limited to: missed payments, late payments, declined payments, or payments not made in full), then a $25 default of payment plan agreement will be applied to the total outstanding balance.**

_____Synergique Healing, PA reserves the right to charge interest, penalties, or consider delinquency at anytime. For this reason Synergique Healing, PA requires the patient to file credit card information for automatic payments to be made as outlined by the payment plan.

_____Synergique Healing, PA is confined to deduct only the minimum payment amount as prescribed below using the patient's credit card information, unless otherwise informed by notification from the patient.

_____The patient agrees to pay Synergique Healing, PA according to the payment schedule reflected below until the patient balance is $0.00.

Please sign and return this original document along with the payment information below. Signature of this document denotes that all parties agreed to the terms of this arrangement.

I will be using the following form(s) of payment: I authorize, Synergique Healing, PA, to charge my credit card:

Credit Card #_____Expiration Date: _____ CVV: _____
Name on Card: _____ Billing Zip Code: _____
Print Patient Name: _____ Date of Birth: _____
Patient Address: _____ Patient Phone: _____

Patient's Signature/Legal Guardian: _____ Date: _____

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