Cambridge Pediatrics, LLC

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PAYMENT AGREEMENT FOR OUTSTANDING BALANCE

This office is happy to extend you the courtesy of allowing you to clear outstanding balance by agreeing to accept payments in weekly, biweekly, or monthly installments. Unless a specific date is noted on this agreement that the balance must be paid by, your account must be paid within 12 months. An exception may be made if you are unable to pay within 12 months; however, in order to qualify, your income, or lack thereof, must be verified.
FUTURE VISITS MUST BE PAID AT THE TIME OF SERVICE!

Name of Patient: _____ D.O.B: _____
If more than one, list below.
Street/PO Box: _____

City: _____ State: _____ Zip: _____

Phone: _____

Financially Responsible Party (FRP)

FRP Name: _____ Phone: _____

Street/PO Box: _____ SS#: _____

City: _____ State: _____ Zip: _____

$_____ Balance to Date

$_____ Down Payment

$_____ Balance Due

PAYMENT PLAN:

_____ Payments at $ _____ Weekly

_____ Payments at $ _____ Biweekly

_____ Payments at $ _____ Monthly

First Payment Due on _____ ACCOUNT # _____

PROMISSORY NOTE*****

I,_____, have read the above agreement and understand the agreement between Cambridge Pediatrics, LLC and myself. I understand that no additional charges can be added to this agreement and that all future visits must be paid at the time of service. If I fail to pay as agreed, I understand that the FULL balance as well as any collection costs will then be due immediately.

_____

Patient Signature Date FRP Signature Date

3500 Old Washington Road, Suite 101 Waldorf, Maryland 20602
Washington Line (301) 843-9236 Waldorf Line (301) 645-1133 Fax (301) 645-2369