PAYMENT PLAN AGREEMENT

I understand that Austin Family Mental Health's policy is: as soon as an unpaid balance reaches $200.00 (two-hundred dollars), no further services will be provided until the balance has been cleared. I will receive one month of my current medication to allow time to find a new provider. It will be the decision of the provider if they wish to begin the working relationship again once the balance is paid.

I, _____, authorize Austin Family Mental Health, P.A.
(print name)
to charge my credit card $_____ on the _____ of every month

until my balance of $_____ is paid in full.

Credit Card Authorization

Patient Name: _____
(Last, First, Middle Initial)

Cardholder Name: _____
(Last, First, Middle Initial)

Address: _____
(Address as it appears on your CC statement) Zip Code Required

Credit Card Information: □ Visa □ Master Card □ Discover □ Amex

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

This form will be securely stored in your clinical file and may be updated upon request at any time.

This is to confirm that I have committed to a contractual agreement with Austin Family Mental Health, P.A. in order to settle a debt that is due. Should I fail to comply or fulfill my agreement, my contract is considered void and I understand that I will need to find a new Provider within 30 days.

Signature: _____ Date: _____