AUTOMATIC WITHDRAWAL FROM CREDIT OR DEBIT CARD
PEDIATRIC PRACTICES OF NORTHEASTERN PA PAYMENT PLAN AGREEMENT

This agreement is between you and Pediatric Practices of Northeastern PA for the sole purpose of payments on your account # __________, in the name of: _________________________________ _________________. By signing this financial agreement, you are bound to pay the disclosed balance in full as set forth in the following payment plan terms. IF at any given time you are unable to make the payment as set forth, you must call our Billing Department at 570-253-9240 within 48 hours PRIOR to payment due date. Should a payment be processed on the due date and the funds are not available, you will be responsible for any fees unpaid, including returned check charges of $35.00 for each item returned and any charges made by your banking institution. You may jeopardize any future payment plan options with Pediatric Practices of Northeastern PA. Any account balance is due within 30 days of billing. If payment arrangements are made to avoid collection activity, the first delinquent payment of this agreement justifies further collection activity, which may be enforced by our Billing Department.

I, ________________________ hereby give Pediatric Practices of Northeastern PA permission to charge my credit card (circle one) MasterCard, VISA, Debit, American Express
ID#______________________________ Expiration Date: ________________
Security # on Back of Card (3 digits) _____________
Cardholder Name: ___________________________
Cardholder Billing Address _____________________________________
____

Social Security # ____________________________. The balance to be paid on is $ __________________, with the following payment dates and amounts to be processed by our Billing Department:

Starting Balance $ __________________

Amount of Payment Due	Due Date	Balance Due	Payment Received

Date: ____________ Signature of Cardholder: ____

Date: ____________ Signature of Account: ____

Date: ____________ Signature of Pediatric Practices of Northeastern PA Agent: ________________

HONORARY
PEDIATRIC PRACTICES OF NORTHEASTERN PA PAYMENT PLAN AGREEMENT

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I, ________________________ hereby agree to an Honorary Payment Plan with Pediatric Practices of Northeastern PA, to which I will send in payment(s) on a ___ weekly, ___ bi-weekly, ___ monthly basis in the amount of $ __________ for the balance owed on my account in the amount totaling $ _________. Should I default on a payment, I understand this contract will be voided and I will immediately be sent to a collection agency for any balance unpaid. Should this occur, I understand the balance must be paid in full prior to any wellness exam.

Amount of Payment Due	Due Date	Balance Due	Payment Received

Date: ____________ Signature of Cardholder: ____

Date: ____________ Signature of Account: ____

Date: ____________ Signature of Pediatric Practices of Northeastern PA Agent: ________________