Seaside Pediatrics
Payment Agreement

Date: _____

Patients Name: _____ Patients Date of Birth: _____

Guarantor Name: _____ Guarantor Phone Number: _____

Terms of Payment Agreement:

- ❖ All payment plans require us having a credit card on file and running the card on a monthly date of your choosing.
- ❖ The guarantor must sign a payment agreement form which will be kept in a secure location.
- ❖ If a credit card declines, we will run it a second time. If it declines again, the guarantor will be called and will have 3 days to respond to the phone call, or the payment plan will be in default, and the balance will be due in full.
- ❖ If the balance is not paid in full at that time, the family will be dismissed from Seaside Pediatrics and the balance due will be turned over to the collection agency.

I agree to pay Seaside Pediatrics, as defined below, on the balance of $_____.

Balances between: $100-$199 may be divided over up to 3 months, $200-$499 divided over up to 6 months, and $500+ divided over up to 9 months.

I authorize Seaside Pediatrics to charge my credit card monthly in the amount of $_____.

☐ On the _____th day of each month until the above balance is paid.

OR

☐ On _____, for a one-time payment.

- o VISA
- o Discover
- o Mastercard

_____ _____ _____

Credit Card Number | Expiration Date | 3 digit security code

I understand that if I default on the terms of this agreement, the payment plan is VOIDED, and my account will be turned over to the collection agency, and my family will be dismissed from Seaside Pediatrics, if the balance is not immediately paid in full.

_____ _____ _____

Guarantor's Signature | Date | Approved By