West Georgia Cardiology

Payment Plan Agreement

Patient Name: _____

Date of Birth: _____/_____/_____

Account No.: _____

This letter will serve as confirmation of a Payment Plan Agreement for your outstanding balance of $_____.

Please indicate the amount you can afford to pay each month, then sign and date your acceptance of this plan, and mail it back with your first payment.

I agree to pay $_____ towards my balance every month. I will be able to make a payment by the end of each month. I understand if I do not receive a statement each month that I am still responsible for providing payment.

☐ I prefer to have the amount debited from my credit card each month (*a Credit Card Authorization Form must be completed*).

I understand all past due payments are required to be paid prior to my next appointment.

I understand if my account is forwarded to a collection agency, I will be responsible for a 35% collection fee in addition to my balance.

_____ _____/_____/_____

Signature Date

If at any time you would like to pay in full, please let us know and we can give you a final total. If you have any questions or need further assistance, please feel free to contact our Business Office at (678) 839-7290. Thank you for the opportunity to assist you in your time of need.