



Payment Plan Terms for Medical Patients

We have payment plans available for medical patients who owe between \$100-\$3000. You can set up your payments to be automatically withdrawn from a checking or savings account or from a credit or debit card. The payments are typically set up on a monthly basis but can be set up on a weekly basis if you prefer. The number of payments and set-up fee depends on the amount you owe.

If you owe:	You'll have this many payments:	And the set-up fee will be:
Under \$100	Sorry, no payment plans available. You need to pay in full.	
\$100-\$199	2 payments	\$22
\$200-\$399	3 payments	\$34
\$400-\$999	4 payments	\$70
\$1000-\$3000	6 payments	\$190
Over \$3000	Sorry, you can only finance up to \$3000 of your bill.	

How to sign up for a payment plan

To sign up for a payment plan just fill out our Auto Recurring Billing Authorization Form and return it to us along with any required paperwork that's asked for on the form, such as a voided check, savings deposit slip or credit card photocopies. Your first payment plus the set-up fee will be due at the time you set up the plan.

Please note that a credit check will be run before your payment plan is set-up if you are applying for \$500 or more in credit. If your credit is denied and we can't set up a payment plan for you, all but \$10.95 of your set-up fee will be credited towards your remaining balance.



Auto Recurring Billing Authorization Form

Patient name: _____ Office Account Number: _____

Person responsible for account (if different than patient): _____

Total bill: \$ _____ Amount of 1st payment: \$ _____ Amount of each additional payment: \$ _____

Start date: _____ End Date: _____

Date of the month payment is to occur: _____

Please choose the method of payment for your recurring payment plan:

Visa
 MasterCard
 American Express
 Checking account
 Savings account

Please provide the required information based upon your method of payment:

Additional pieces of information are required for authentication. Please see the back of this form for examples.

Checking/Savings Account Information

A voided check or savings deposit slip is required for this method of payment.

Name on acct: _____

Bank name: _____

Routing #: _____

Account #: _____

Billing Address: _____

City, State, Zip: _____

Phone: _____

Credit/Debit Card Information

A photocopy of BOTH sides of your credit/debit card is required for this method of payment.

Cardholder Name: _____

Card #: _____

Exp. Date: _____ Security Code: _____

Billing address: _____

City, State, Zip: _____

Phone: _____

- Yes, I would like a copy of my monthly statement mailed to my home.
 No thanks, I don't need one.
 I would like a monthly receipt emailed to me at the following email address: _____

I hereby authorize Robert B. Hopp, MD, to run a check on my credit if I'm applying for \$500 or more in credit and to automatically debit/charge my account indicated above using the payment, date, and account information provided on this form. All information provided on this form is true and correct. Cancellation of this payment agreement must be done in writing **along with** payment in full. I understand that this payment agreement will not cease until payment in full is received.

Signature: _____ Date: _____

Witness: _____ Date: _____

Examples of required forms

Voided Check:

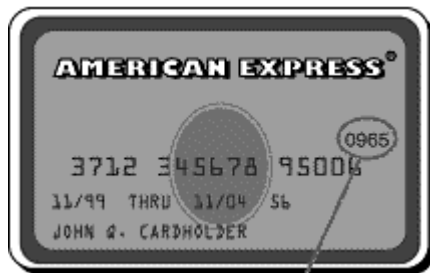


Routing Number 241022233
(9 digits; begins w/ 01-12 or 21-32)

Account Number 333962222

Check Number 2048

Credit or Debit Card Photocopies (both front & back):



&



Savings Account Deposit Slip:

NAME
ADDRESS
CITY, STATE, ZIP

DATE
DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL

SIGN HERE FOR CASH RECEIVED (IF REQUIRED)

BANK NAME
ADDRESS
CITY, STATE, ZIP

CASH DEPOSITS

CHECK OR TOTAL FROM OTHER SIDE

SUB-TOTAL

LESS CASH RECEIVED

\$

⑆0 234 56 78⑆ 0 234 56 78 90 23⑆

Bank Routing Number Bank Account Number