

# CARY CARDIOLOGY, P.A.

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## PATIENT BUDGET PLAN AGREEMENT

Patient Name: \_\_\_\_\_

Patient Account: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Total Balance: \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

Payment Today: \$ \_\_\_\_\_ Monthly Payment(s): \$ \_\_\_\_\_

### FOR BUDGET CREDIT CARD PAYMENTS:

Visa, Master Card, Discover,  
American Express

Card Type: \_\_\_\_\_

Debit Day: 15th of the month

Card No. \_\_\_\_\_

Expiration: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Zip: \_\_\_\_\_

*I, the patient of Cary Cardiology, PA understand and give my consent for the payment information to be used by Cary Cardiology, P.A. to process payments on my behalf until the balance has been paid in full. Once the balance is paid in full, all debits will cease, unless reinstated by me.*

*I, the patient of Cary Cardiology, PA have been informed and concur that today's agreement will be in force until the Total balance is PAID IN FULL. Delinquent payments may VOID this agreement and I may be subject to any collection actions required to collect this balance in full if the account becomes delinquent and/or outstanding.*

*I understand that any additional charges incurred by me, prior to the balance being paid in full, will be added to the prior balance, unless I notify Cary Cardiology P.A. in writing and make a full payment .*

\_\_\_\_\_  
Signature of patient (or responsible party)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Cary Cardiology employee witnessing

\_\_\_\_\_  
Date