

CARY CARDIOLOGY, P.A.

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PATIENT MONTHLY DEBIT PLAN AGREEMENT

Patient Name:	_____	Patient Account:	_____
Mailing Address:	_____ (Address: Include Apt, Suite, Bldg, etc.)		
Total Balance:	\$ _____		
Payment Today:	\$ _____	Effective Date:	_____
Debit Payment(s):	\$ _____	Debit Day:	_____
Card Type:	_____ Visa, Master Card, Discover, American Express, Visa Debit <small>(CIRCLE ONE)</small>	Expiration:	_____
Name on Card:	_____	Zip:	_____

I, the patient of Cary Cardiology, PA understand and give my consent for the above information to be used by Cary Cardiology, P.A. to process payments on my behalf until the balance has been paid in full. I will receive statements showing the activity and balance on my account.

I also understand that any additional charges incurred by me, prior to the balance being paid in full, will be added to the debit balance, unless I notify Cary Cardiology P.A. in writing. Once the balance is paid in full, all debits will cease, unless reinstated by me on future balances.

I have been informed and concur that today's agreement will be in force until the Total Balance is PAID IN FULL. Any delinquent payments (ie: card expiration, cancellation made in writing by the patient, etc.) will 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.

Signature of patient (or responsible party)

Date

Signature of Cary Cardiology employee witnessing

Date

ALL INFORMATION IS CONFIDENTIAL AND WILL BE USED FOR THE SOLE PURPOSE LISTED ABOVE