Patient's Name: ____________________________________ **Account #:** ________________

FAAWC PATIENT PAYMENT AGREEMENT

I agree to pay Foot & Ankle Wellness Center (FAAWC) for medical services and supplies I have received in the amount of $___________ (dollar amount), every _________________ (time period), starting ________________ (date), until the total balance of my account is paid. I understand that co-pays for future visits are not included in this amount.

I understand that if there is a problem receiving payment, FAAWC may choose to send my account to an outside collection agency to obtain full payment.

I understand that a finance charge of 0.6% will accrue monthly only if my credit card payment to FAAWC fails to clear.

Signed: ____ ☐ **Verbal**

Witnessed: ____ **Date:** ___________

I authorize Foot & Ankle Wellness Center to keep my signature on file and to charge my credit card account monthly for each payment. I understand that this form is valid until the account balance has been paid in full, unless I cancel the authorization through written notice to FAAWC's office.

Your credit card information is kept highly confidential.

Cardholder Name: ____

Card Number: _________________________________ **Expiration Date:** ___ / ____

Cardholder Signature: ____ ☐ **Verbal**

Billing ZIP Code: ____