WEST TN NEUROLOGY

Ph: 901 213 4225, Fax: 901 213 4226
info@westtnneurology.net
6570 Stage Rd #202, Bartlett, TN 38134

Patient Payment Plan

I, Parent/Guardian of, the patient _____, (Account # _____) understand that I agree to the following payment plan between myself and West Tennessee Neurology. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the time frame listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. In today's economic times, we understand the hardships you may be going through, and we want to work with you to resolve your balance. This payment plan will start only if no payment is made towards your balance in 120 days. Listed below are our payment plan options.
2. After 120 days full outstanding balance will be put on 6 month payment plan with 6 equal payments
3. The credit on file will be charged every month for installment amount for the next 6 months.
4. My current patient account balance is $____as of (date) ___.

   Are claims still pending with insurance? (Circle) Yes No

   I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well. Patient's (or Guarantor's) Initials _____
5. I hereby authorize West Tennessee Neurology to deduct the payment amount monthly on the 1st of every month from my debit/credit card account:

   Type of Card (Circle): Mastercard Visa American Express Discover

   Account #: _____
   Expiration Date: _____ V-Code (3 digit security code): _____ Billing Address Street #: _____ Billing Zip Code: _____
6. Any questions or concerns that I may have had concerning this agreement were answered or discussed with one of the staff members at West Tennessee Neurology. If this agreement needs to be altered at any time, I will contact the office, at 901-213-4225 to discuss further options.

   Patient's (or Guarantor's) Initials _____

_____ Patient or Guarantor Printed Name

_____ Patient or Guarantor Signature

_____ Date Signature

_____ Witness: Staff of West Tennessee Neurology