Date:

Payment Plan for:
Acct#: EIP2-

PLEASE NOTE that this arrangement is inclusive to the specific dates and current account balance within this document. Any further charges would be due at time of service, or would require a separate payment plan.

Date(s) of Service:

Total current account balance: $

Please accept the following monthly payment agreement. I have selected the appropriate option per my balance due to make my payments more manageable.

- _____ monthly payments of $

****Please note: Your first payment should be included with this signed document and returned upon receipt unless otherwise arranged verbally. Please mail payments to…

Eastern Indiana Podiatry
744 N State St
Greenfield, IN 46140

Should you have any questions concerning this document or your account please feel free to call us at Podiatry Practice Helpers (317) 747-4747.

Thank you for your assistance in getting this matter resolved.

Patient's Signature: _____ **Date:** _____

Guarantor's Signature: _____ **Date:** _____

Billing Manager _____ **Date:** _____