DFW Endocrinology

Payment Plan Agreement & Credit Card Authorization

Patient Name:

Date of Birth:

Phone Number:

Email:

Total Balance Due ($):

Agreed Payment Schedule

Installment 1: Date (MM/DD/YYYY) Amount ($)

Installment 2: Date (MM/DD/YYYY) Amount ($)

Installment 3: Date (MM/DD/YYYY) Amount ($)

Installment 4: Date (MM/DD/YYYY) Amount ($)

Installment 5: Date (MM/DD/YYYY) Amount ($)

Credit Card Authorization

Name on Card:

Card Number:

Expiration (MM/YY):

CVV:

Billing ZIP Code:

I understand that this payment plan is a financial agreement between myself and DFW Endocrinology.
I authorize recurring charges to my credit card as outlined above without additional notification.
If a payment is declined, I understand that I am responsible for providing an updated payment method immediately.
Missed or declined payments may result in the remaining balance becoming due in full.
I understand that failure to comply with this agreement may result in additional collection efforts.

Patient Signature:

Date: