Longleaf Wellness and MFM Center

(Insert Logo Here)

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Account #: _____

This document serves as an agreement for an approved payment plan based upon policies set by Longleaf Wellness and MFM Center.

The patient listed above agrees to this payment plan as outlined below for the outstanding account balance. If the patient deviates from the plan (including, but not limited to: missed payments, late payments, declined transactions, or incomplete payments), Longleaf Wellness and MFM Center reserves the right to charge interest, penalties, or consider the account delinquent.

For this reason, Longleaf Wellness and MFM Center requires patients to provide credit card information for automatic payments according to the plan. The Center will deduct only the minimum agreed payment unless notified otherwise by the patient.

The patient agrees to pay Longleaf Wellness and MFM Center $_____ per month starting _____. This amount will be collected on the fifteenth of each month until the balance is paid in full.

Please sign and return this form with your payment information. Your signature acknowledges agreement with the terms of this arrangement.

■ Payments will be made by credit card, which I authorize you to use:

■ Visa	_____	Exp: ___/___	CID: _____
■ MasterCard	_____	Exp: ___/___	CID: _____
■ American Express	_____	Exp: ___/___	CID: _____
■ Other	_____	Exp: ___/___	CID: _____

Name on Card: _____

Signature: _____

Date: _____