



PLANO
 6101 Windcom Court
 Suite 400
 Plano, TX 75093
 Ph: (972) 398-3500
 Fax: (972) 398-3512

DENTON
 3105 Colorado Blvd.
 Suite 101
 Denton, TX 76210
 Ph: (940) 387-1700
 Fax: (940) 387-1722

DENISON
 5012 South US HWY 75
 Suite 150
 Denison, TX 75020
 Ph: (903) 463-8400
 Fax: (903) 463-8500

Patient Name: _____
 Patient Address: _____

 City, State, Zip _____
 Date of Birth: _____ Gender: _____
 Daytime Phone: _____ (Hm/Wk/Mb)
 Provider: _____

Installment Payment Agreement

- ◆ I, _____, hereby agree to pay Southwest Allergy and Asthma Center the balance of \$ _____ owed on the account under the name(s) _____. Said payment in the amount of \$ _____ per month, due on the _____ day will begin on _____.
- ◆ I, _____, give consent to Southwest Allergy and Asthma Center to retain my credit/debit card information on file until the debt addressed in this agreement is paid in full. I understand that if at any time the card should become inactive or reach its printed expiration date, I will notify Southwest Allergy and Asthma Center within 10 days and provide an alternative means of payment.
- ◆ I understand if a payment is delinquent, I have 5 days to make agreed installment payment. If I fail to do so, the result will be legal action without further notification.
- ◆ I attest that the information provided to Southwest Allergy and Asthma Center in this agreement is true and correct and if there are future changes in my billing or contact information, it is my responsibility to contact Southwest Allergy and Asthma Center within 10 days of said change to update this information.

My current contact information is as follows:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Primary Telephone: _____
 Secondary Telephone: _____

My current credit/debit card information is as follows:

Name on Card: _____
 Card Number: _____
 Expiration Date: _____
 Billing Address: _____

 Patient's Printed Name

 Patient's Signature

 Date

 *Legal Representative's Printed Name

 Legal Representative's Signature

 Date

**If representative, specify relationship to patient*

 Witness

 Date