Patient Name:_____ Date of Birth: _____
Patient Address: _____ Gender: _____
_____ Daytime Phone: _____
Provider: _____ Date: _____

# 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