**MARIETTA PSYCHIATRY ASSOCIATES PC**
**670 North Ave NW, Suite 200,**
**Marietta, GA 30060-1100**
**Phone: 770-678-7034 Fax: 770-678-7035**

# PATIENT PAYMENT PLAN

I, ___________________________, the patient, (Account # __________) understand that I agree to the following payment plan between myself and MARIETTA PSYCHIATRY ASSOCIATES PC. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the time frame listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. In today's economic times, we understand the hardships you may be going through, and we want to work with you to resolve your balance. This payment plan will start only if your balance is not paid in full in 120 days. Listed below are our payment plan options.

Payment Plan

| Balance | Minimum Payment Amount |
|---|---|
| Under $100 | $25 per month |
| $100 - $200 | $35 per month |
| $201 - $300 | $45 per month |
| $300 or above | $50 per month |

2. My current patient account balance is $________as of (date) ___________.

   Are claims still pending with insurance? (Circle) Yes No

   I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well.

3. The monthly payment will be $______and payment will be due on the _____of each month.

4. I hereby authorize MARIETTA PSYCHIATRY ASSOCIATES PC to deduct the payment amount monthly on the day indicated above

from my debit/credit card account:

Type of Card (Circle): MastercardVisa American Express Discover

Account #: ______________________________
Expiration Date: __________Code (3 digit security code):
Billing Address Street #: _________________Billing Zip Code: __________

5. Any questions or concerns that I may have had concerning this agreement were answered or discussed with one of the staff members at MARIETTA PSYCHIATRY ASSOCIATES PC. If this agreement needs to be altered at any time, I will contact the Mohammed Y. Abubaker, MD, at 770-678-7034 to discuss further options.

Patient's (or Guarantor's) Initials _____

| ______________________________ | ______________________________ |
|---|---|
| Patient or Guarantor Printed Name | Patient or Guarantor Signature |
| ______________________________ | ______________________________ |
| Staff of MARIETTA PSYCHIATRY Signature | Date |