ALLIANCE
PROSTHETICS + ORTHOTICS

This document is to act as a set agreement for an approved payment plan based upon policy set by Alliance Prosthetics and Orthotics.

The patient listed below will agree to this payment plan as prescribed below for the patient's outstanding account balance. Should the patient deviate from the prescribed payment plan at any time (including but not limited to missed payments, late payments, declined payments, or payments not made in full) Alliance Prosthetics and Orthotics reserves the right to charge interest, penalties, or consider delinquency at any time. For this reason, Alliance Prosthetics and Orthotics requires the patient to file credit card information for automatic payments to be made as outlined by the payment plan.

Alliance Prosthetics and Orthotics is confined to deducting only the minimum payment amount as prescribed below using the patient's credit card information, unless otherwise informed by notification from the patient.

The patient agrees to pay Alliance Prosthetics and Orthotics $ _____ per _____ starting _____ until the balance is $0.00. The current balance remaining: _____

Please sign and return this original document along with the payment information form. The signature of this document denotes that all parties agreed to the terms of this arrangement.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____

Name on Card:	
Card Number:	
Expiration Date:	
Security Code:	
Billing Zip Code	