HORN LAKE FAMILY PRACTICE
PATIENT PAYMENT PLAN

I, _____, the patient, (Account # _____) understand that I am agreeing to the following payment plan between myself and Horn Lake Family Practice (HLFP). I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. We understand the hardships you may be going through, and we want to work with you to resolve your balance. 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. **Patient's (or Guarantor's) Initials** _____

3. The monthly payment will be $_____ and payment will be due on the _____ of each month.

4. I hereby authorize Horn Lake Family Practice to deduct the payment amount monthly on the day indicated above from my debit/credit card account:

Type of Card (Circle): Mastercard / Visa / American Express / Discover
Card #: _____
Expiration Date: _____ V-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 Horn Lake Family Practice. If this agreement needs to be altered at any time, I will contact the HLFP Office at 662-342-6676 to discuss further options. **Patient's (or Guarantor's) Initials** _____

_____ _____
Patient or Guarantor Printed Name Patient or Guarantor Signature

_____ _____
Date Witness: Staff of HLFP Signature