AUTOMATIC PAYMENT PLAN

We at Pediatric Partners, LLC understand in today's economic climate that it may not always be possible to pay bills in full. We are determined to make sure our patient's health issues are addressed and are therefore willing to make the following payment arrangements:

Patient Name(s): _____

_____

Family #: _____

I authorize Pediatric Partners, LLC to automatically charge my credit card (Visa, Mastercard, Discover, debit card, health savings account):

- ❑ Weekly in the amount of $_____.
- ❑ Monthly in the amount of $_____.
- ❑ One time only in the amount of $_____.

Card Number: _____

Expiration Date: _____ 3 Digit Security code: _____
(found on back of card)

Name on Card (please print): _____

Signature: _____

For your convenience this form may be mailed or faxed to our billing office at:

410-751-7113
Pediatric Partners, LLC
PO Box 812
Westminster, MD 21158

Thank you.