

**813 Lower Mill Bay Rd. Kodiak, AK 99615**

**P(907)486-4499 F(907)486-8211**

**arcticpt@gmail.com**

**Payment Plan**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Monthly payment amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment due on \_\_\_\_\_\_\_\_\_\_ day of the month.

Payments will be made by check \_\_\_or cash \_\_\_

Please process my monthly payment on a debit \_\_\_ or credit card \_\_\_

 Credit Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Card Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Balance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If my payments are not made on the day that was chosen, I understand my account will be turned over to a collection agency. If my payments will be made by credit card, I authorize Arctic Physical Therapy Services, Inc. to process monthly payments from my credit card until my balance is zero.

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Patient/Guarantor Signature Clinic Representative