Chiro Branch Location
124 Franklin Street
Orlando, Fl 32822
www.chirobranch.com
407-999-0000
Payment Plans: 877-838-1148

Payment Plan Agreement

Patient Name:	Jack Bauer	**Plan ID:**	BC1E9791-A4N3CH2F	**Address:**	125 Gem Stre Tampa, FL 33634
Date of Birth:	2/1/2009	**Email:**	JB@aol.com		
Patient ID:	JB - 10876	**SSN:**	6889	**Home Phone:**	813-555-1234
DL State:	FL	**DL #:**	FL 123-678	**Work Phone:**	813-940-1265
				Mobile Phone:	727-123-5555

Patient Care Plan Details

Description	# of Units	Unit Price	Total Price
72010 X-RAY EXAM OF SPINE	2	$110.90	$221.80
98943 CHIROPRACTIC MANIPULATION	20	$47.14	$942.80
99204 OFFICE/OUTPATIENT VISIT NEW	1	$150.00	$150.00
		Total	**$1,314.60**

Care Plan Terms and Conditions

I can terminate my treatment plan at any time and acknowledge that I will be responsible only for those products and services that were provided me. Furthermore, I acknowledge that certain medical products, supplements or prescriptions provided to me are nonrefundable under any circumstances. Initial ________

I acknowledge that my provider has contracted with ClearGage, Inc., dba Healthcare Payment Solutions to act as its administrator of this payment agreement. Furthermore I acknowledge that my provider may assign, transfer, sell or pledge this payment plan agreement to any third party under the terms herein. Initial ________

All questions about your balance and payment history or to update you payment profile, please contact customer service at 877-838-1148. Initial ________

Financial Transaction Details

Description	Charges	Receipts	Balance
Initial Liability (10/10/2013)	$1,314.60		$1,314.60
Setup Fee	$15.00	($15.00)	$1,314.60
Payments Made		($328.65)	$985.95
Remaining Liability	**$1,329.60**	**($343.65)**	**$985.95**

Payment Plan Details

Service Fee (per Payment)	$18.08	**Payment Frequency**	Monthly
5 Payments of	$182.41	**Payment Date**	
Final Payment of	$182.37	**Payment Method (Primary)**	VISA-1111
Total Payments	6	**Payment Method (Alternate)**	Checking-3131
Total Estimated Service Fees	$108.47		
Total Payment Amount w/Fees	$1,094.42		

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Fees and Assessments Acknowledgement

I understand that I am paying a One Time Payment Plan Set Up fee of:	$15.00	Initial ________
I understand that I am paying a payment plan service fee of:	11%	Initial ________
I understand that an additional service fee will be assessed for any check, draft, credit card, or order returned for insufficient funds or returned or declined for any other reason. This fee is:	$20.00	Initial ________
I understand that should any monthly payment become more than ten (10) days past due, I will be charged a fee of:	$30.00	Initial ________

Payment Plan Terms and Conditions

By providing my email address and/or mobile phone number I consent to receive emails and/or text messages regarding my payment activity. I agree to pay according to the payment schedule above and I hereby attest that I am the owner of the bank account(s) or credit/debit card(s) referenced herein. Furthermore, should any payment obligation as called for in this agreement become more than sixty (60) days late my provider shall have the right to declare me in "default" and the entire remaining balance shall become immediately due and payable, and my provider reserves the right to debit either my primary or secondary payment account for the full balance owed. I understand that should a default occur I may be responsible for additional charges related to the costs of collection, including but not limited to collection agency fees, court costs, and attorney fees.

To the extent that you request additional products or services or modifications to your existing Patient Care Plan, payment for such products and services will be in accordance with this agreement.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Provider Representative Date

Name: Chip Hunziker
IP: 75.115.82.38
Date: 10/10/2013 11:35 AM

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