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

Payment Plan Agreement

Patient Name:	Teri Bauer	**Plan ID:**	B4QZIV5R-AB857P8J	**Address:**	
Date of Birth:	2/12/1969	**Email:**			
Patient ID:		**SSN:**		**Home Phone:**	
DL State:		**DL #:**		**Work Phone:**	
				Mobile Phone:	

Patient Care Plan Details

Description	# of Units	Unit Price	Total Price
Ear / eye / dental exam	6	$25.00	$150.00
Physical exam	6	$45.00	$270.00
Fecal exam	3	$25.00	$75.00
Vaccination	2	$25.00	$50.00
		Total	**$545.00**

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 _____

All questions about your balance and payment history or to update your payment profile, please contact the provider directly. Initial _____

Financial Transaction Details

Description	Charges	Receipts	Balance
Initial Liability (09/20/2013)	$545.00		$545.00
Setup Fee	$15.00	($15.00)	$545.00
Payments Made		($50.00)	$495.00
Remaining Liability	**$560.00**	**($65.00)**	**$495.00**

Payment Plan Details

Service Fee (per Payment)	$0.00	**Payment Frequency**	Monthly
10 Payments of	$45.42	**Payment Date**	5th
Final Payment of	$40.80	**Payment Method (Primary)**	Checking-3131
Total Payments	11	**Payment Method (Alternate)**	VISA-1111
Total Estimated Service Fees	$0.00		
Total Payment Amount w/Fees	$495.00		

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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:	$0	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: 09/20/2013 09:29 AM