VALLEY ARTHRITIS CARE, LLC

Financial Agreement Letter

First Name: _____ Last Name: _____

Date of Birth: _____

Account #: _____ Balance Due: _____

I acknowledge and understand the above balance is my responsibility and agree to make the following payment arrangements written as follows:

For balances $500.00 or less:

☐ I agree to pay Valley Arthritis Care, LLC, the amount of $ _____ each month for 6 months.

For balances over $500.00 but less than $1000.00:

☐ I agree to pay Valley Arthritis Care, LLC, the amount of $ _____ each month for 10 months.

For balances over $1000.00:

☐ I agree to pay Valley Arthritis Care, LLC, the amount of $ _____ each month for 12 months.

I hereby authorize Valley Arthritis Care, through the billing personnel, to debit my credit/debit card left on file. I understand that failure to keep this financial agreement for any reason, may result in the decision of Valley Arthritis Care to discharge me from the practice. I further understand that I will update and fill out a new financial agreement letter if there are any changes to this credit/debit information that I have provided.

Credit / Debit Card#_____

Card Type: _____

Expiration Date: _____ Security Code: _____ Zip Code:_____

Date of Transaction will be effective _____ and repeating every month on the _____ of the month.

Patient Signature_____ **Date:** _____

Billing Personnel Printed Name: _____

Billing Personnel Signature: _____**Date:** _____

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