



LANDMARK INTERNAL MEDICINE
7615 Clarington Cove,
Southaven, MS 38671
Phone: (662) 536-2500 Fax: (662) 536-2505

PATIENT PAYMENT PLAN

I, _____, the patient, (Account # _____) understand that I agree to the following payment plan between myself and LANDMARK INTERNAL MEDICINE. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the time frame listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. In today's economic times, we understand the hardships you may be going through, and we want to work with you to resolve your balance. This payment plan will start only if your balance is not paid in full in 120 days. Listed below are our payment plan options.

Payment Plan	
<u>Balance</u>	<u>Minimum Payment Amount</u>
Under \$100	\$25 per month
\$100 - \$200	\$35 per month
\$201 - \$300	\$45 per month
\$300 or above	\$50 per month

2. My current patient account balance is \$_____ as of (date) _____.

Are claims still pending with insurance? (Circle) Yes No

I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well.

3. The monthly payment will be \$_____ and payment will be due on the ____ of each month.
4. I hereby authorize LANDMARK INTERNAL MEDICINE to deduct the payment amount monthly on the day indicated above from my debit/credit card account:

Type of Card (Circle): Mastercard Visa American Express Discover

Account #: _____

Expiration Date: _____ Code (3 digit security code):

Billing Address Street #: _____ Billing Zip Code: _____

5. Any questions or concerns that I may have had concerning this agreement were answered or discussed with one of the staff members at LANDMARK INTERNAL MEDICINE. If this agreement needs to be altered at any time, I will contact the Zeba Rashid, at 347-590-6565 to discuss further options.

Patient's (or Guarantor's) Initials _____

Patient or Guarantor Printed Name
Signature

Patient or Guarantor

Date
Signature

Witness: Staff of CMNY