Shepherd Healthcare
Tim Shepherd, MD, PA
Diplomate of American Board of Family Practice

CONSENT TO PAYMENT PLAN

I, _____, agree to pay Shepherd Healthcare, for my outstanding balance owed to Dr. Timothy Shepherd, on the following payment plan:

My total balance owed is: $_____, and does not include today's or any future charges.

I agree to pay $_____ on the following Friday of the month:

- First Friday
- Second Friday
- Third Friday
- Fourth Friday

If I fail to follow this payment plan, I understand that my balance may be sent to collections without any further notification and I may be required to pay my full balance on my next visit.

If my credit card is declined through my bank account, I may be required to pay my full balance before my next visit and/or be denied to make payment plans in the future.

Patient signature: _____ Date: _____

Please provide credit card information below, once balance has been paid in full a record of this will be placed in my chart with only the last 4 digits of my credit card number visible.

Type of credit card: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

Card# _____ Exp _____ CVV _____

Name on card _____

Billing address for card _____

City _____ Zip _____

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