

TLC PEDIATRICS L.L.C.

4315 NORTHVIEW DRIVE BOWIE, MD 20716

OUTSTANDING BALANCE AND PAYMENT AGREEMENT

I authorize TLC Pediatrics L.L.C. to charge my credit card for the payments on the balance of charges for which I am responsible and to keep my signature on file.

(Please Print Clearly)

Patient Acct # _____

Patient Name: _____ D.O.B. _____

Total Balance on Acct.: \$ _____ Authorized Charge Amount \$ _____

Payment Plan (check one): Weekly ___ Biweekly ___ Monthly ___

Office Use Only:

Additional Notes: _____

Credit Card Number _____ EXP. Date _____

3 Digit Security Code: _____ Visa/ Master Card/ Discover

Card Holder Information(as it appears on card)

Name: _____ SSN# _____ - _____ - _____

Address: _____

Contact Number:(_____) _____ - _____

I understand that I have authorized TLC to charge my account for the scheduled payment plan and to keep my signature on file. If scheduled payment needs to be cancelled a written request needs to be received by TLC Pediatrics 3 business days prior to scheduled payment date to allow proper processing. Unless a specific date is noted on this agreement the outstanding balance must be paid within six months. I understand this is solely my responsibility to ensure all payments are received on time and/ or proper cancellation is received in a timely manner.

Printed Name of Authorizing Parent/ Guardian

Signature