VILLAR NEUROPSYCHOLOGY

Payment Plan Agreement

I, _______________________________________, agree to remit the following payments to **Villar Neuropsychology**:

	Amount	Due Date	Payment Date	Form of Payment	Follow-up
Payment #1					
Payment #2					
Payment #3					
Payment #4					
Payment #5					

This payment plan is **interest free** and free of billing charges for the payment period; however, I understand that in the event any of my payment is more than **30 days** late, **Villar Neuropsychology** will add a late fee of **$25.00** to my account. This fee is enforced to keep costs at a reasonable level, thus preventing frequent increases in the fees for medical services provided by **Villar Neuropsychology**.

Method of Payment:

__ **Personal Check(s)**

__ **Cash**

Credit Card (Check One):

__ **Visa**

__ **Mastercard**

Credit Card Authorization:

Last 4 digits of Credit Card Number: _______________________ Expiration Date: ___________________

I, _____________________________, authorize Villar Neuropsychology to keep my signature on file and to charge my payments to the credit card selected above.

Signature of Responsible Party/Card Holder: _________________________Witness: __________________

Print Name of Responsible Party/Card Holder: ______________________ Date: _____________________

Print Patient Name: ____

Address: ______________________________ City: ____________________ State: ______ Zip: __________

Telephone: ____________________________