CARDIOVASCULAR CARE CENTER &CRC
CARE IS OUR MIDDLE NAME

1372 Wellbrook Circle NE, Conyers GA 30012
Phone: 470-500-CARE (2273) Fax: 470-289-5440

FINANCIAL ARRANGEMENTS FORM

Date: ___/____/____

Patient Name: _____ Acct#: _____

This is an agreement between the patient (listed above) and Cardiovascular Care Center & CRC that a monthly payment plan has been put in place in the amount of $_____. The first payment is due (date)_____. The patient agrees to have their debit/credit card processed on the (date) _____ every month until the balance of $_____ is paid in full. If the balance increases, another agreement will need to be signed.

Late Payment
The patient understands that if the card declines twice within two business days, the office will call them and give them an opportunity to pay with another card. Patient understand the payment plan will be considered delinquent and the contract will be voided if payment is more than five (5) days late.

I have read the above description of the financial arrangements and agree to its terms.

_____ _____
Signature of Patient, Parent, or Legal Representative Date

_____ _____
Witness Date

Debit/ Credit Information
Please note there is a 3% fee for all credit card transactions.

Visa Mastercard Discover

Card#: _____ Expiration date #: _____/____
Security code: _____