Monthly Payment Agreement Contract

Patient Name: ________________________________ Date: ___ ___/___ ___/___ ___

Terms

I understand that I am entering into a Monthly Payment Agreement Contract between myself and **Reliant, Inc.** I further understand that I must sign and return this agreement for it to be executed. *By signing below I understand that I will be held responsible for and consent to making my monthly payment by the 1st of each month on my account. I am aware that any late payment on this Payment Agreement Contract will result in a $25 late fee being assessed and/or my account being sent to a collection agency.*

Monthly Payment Options (Choose one below)

- ○ **Credit Card Authorization: (Recommended)**

  **Processed the first day of each month until account is paid in full. .*

  Name on Credit Card: ____

  Billing Address for CC: ____

  ____

  Type of Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ AMEX

  Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

  Expiration Date: ___ ___ / ___ ___ ___ ___

  Security Code/CVV: ___ ___ ___ ___

- ○ **I will make my monthly payment every month.** (*If you choose this option it is your responsibility to make your payment by the first of the month. Please mail a check or CC information to our company headquarters at 105 Summit Grv; Brandon, MS 39047 or make a payment online at our website www.ReliantPT.com/payment/*)**.**

Minimum Monthly Payment:

- ○ **$20/mo**: account balances between $30 - $200
- ○ **$30/mo:** account balances between $201 - $350
- ○ **$40/mo:** account balances between $351 - $500
- ○ **$50/mo:** account balances over $500
- ○ ______**:** Other Amount (If you desire to pay more than your minimum payment.

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Patient Signature

Please return this signed form by mail to Reliant PT at 105 Summit Grove; Brandon, MS 39047 or email to Info@ReliantPT.com.