



Payment Plan Request Application

HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC allows patients and/or clients to pay their outstanding balance over time in monthly payment plans. Standard payment plans are at least \$50 monthly. **Payment plan request cannot exceed four (4) months.** If you are receiving or are eligible for government assistance, you may be able to get monthly payment as low as \$20 monthly and twelve (12) months to complete your payment plan.

HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC is currently accepting applications for payment plans. To apply, complete, sign and return this form to our office for consideration.

How the Payment Plan Agreement Works

By entering into this payment plan agreement, you are agreeing to pay your outstanding account balance in timely monthly payments instead of paying the total amount due in full. You will periodically receive billing notices for the total amount due on your account. Please continue to remit at least your monthly payment amount due.

Chiropractic Care While on a Payment Plan Agreement

To resume and/or continue chiropractic care and/or physiotherapy (PT) services at our office, you must have a zero balance on your account or have prior written approval from our practice manager.

Avoid Third-Party Collections

To avoid having your account sent to a third-party for collections, **please make your payments on a timely matter.** Your account does not accumulate interest or fees unless it is submitted to a third-party for collections. **To avoid your account being sent to a third-party collections' agency, we highly recommend that you work directly with us to resolve your outstanding account balance.** We are willing to work with you.

Application Review

If your payment plan request is approved, we will mail a copy of the plan agreement, which includes a payment schedule. Your first payment will be due thirty (30) days from the agreement date. If your request is not approved, we will contact you to tell you why and discuss your options.

Common reasons a payment plan request may be denied:

- You were given a previous payment plan and you did not complete.
- The monthly amount you asked for would take too long to pay your account in full.

If you do not hear from us about the status of your payment plan application within 15 business days, please contact us at **240-264-6372**.

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC

10 South Street, Suite 403, Baltimore, Maryland 21202

Phone: 240-264-6372 | Fax: 1-888-375-5167

www.driffanybutler.com

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Last updated on 01/01/2024

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Patient Information

First and Last Name _____ DOB: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Email Address: _____

Payment Information

Balance Due (if known) \$ _____ Preferred Due Date: _____

Preferred Monthly Payment Option: Option 1 Option 2 Option 3

| Option 1 | Option 2 | Option 3 |
|---|---|--|
| Divide total balance into four (4) equal payment amounts. | Pay \$50 a month until balance is paid off. | I would like to pay \$ _____ a month until paid off. |

Send pages 2 – 3 to our office by mail or fax.

Mail:
Harmonious Living Chiropractic
PO Box 558
Columbia, Maryland 21045

Fax:
1-888-375-5167.

Patient/Legal Guardian Printed Name Patient/Legal Guardian Signature Date

DO NOT SEND THIS FORM VIA EMAIL. RETURN FORM BY MAIL OR FAX TO OUR OFFICE ONLY.

Recurring Credit Card Payment Authorization

(Print clearly and legibly)

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Credit Card Information

Card Type: MasterCard Visa Discover AMEX

Cardholder Name (as shown on card): _____

Card Number: _____ Expiration Date (MM/YY): _____ Security Code: _____

Cardholder ZIP Code (from credit card billing address): _____

Credit Card Cardholder Information

Name: _____

Address:

Email Address: _____ Cell Phone: _____

By completing this form, I agree to regularly scheduled charges to my credit card. I will be charged the amount indicated below each billing period. A receipt for each payment will be provided to me and the charge will appear on my credit card statement. I agree that no prior notification will be provided unless the date or amount changes, in which case I will receive notice from us at least ten (10) days prior to the payment being collected.

I, _____ authorize HARMONIOUS LIVING

CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC to charge my Credit Card indicated for services provided to me for \$_____ on the _____ of each month. I understand that my information will be saved to file for future transactions on my account until the account has been satisfied.

Credit Card Cardholder Signature

Date

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