Smith
PSYCHOLOGICAL SERVICES
smithpsychologicalservices.com

Home Office
1401 Airport Pkwy, Suite 240
Cheyenne, WY 82001

Branch Office
1635 Foxtrail Dr
Loveland, CO 80538

Tel: 307-632-7771

Payment Plan Agreement

Date: _____

Patient's Name: _____

Address: _____

_____ Phone: _____

Credit Card on file: _____

Expiration Date: _____ CVV code: _____

Amount Due Monthly: _____

Date Due each month: _____

I hereby agree to make monthly payments to Smith Psychological Services in the amount indicated above until my account balance is paid in full. If I fail to make a payment or make arrangements ahead of my scheduled due date, I hereby agree to have my missed payment charged to the credit card on file. I am responsible for keeping my credit card information up to date and agree to inform Smith Psychological Services of any changes as soon as possible. Smith Psychological Services will also have full discretion for unpaid accounts and will take necessary actions to collect any unpaid balances.

_____ _____
Patient/Responsible Party Date

_____ _____
Witness – Smith Psychological Services Date