UNION PHYSICAL THERAPY

Mitch Owens MSPT, COMT
Elisa Owens DPT, CMPT
Sarah Wyant DPT
Dustin Steffan DPT

Payment Plan Agreement

Patient's Name: _____ Date of Birth:_____

Previous Name (if applicable): _____

In order to continue my care at Union Physical Therapy I agree to the following: A payment of $40.00 will be made at the time of service for each of my appointments going forward. In addition to the $40.00 per visit fee I agree to make a minimum monthly payment of at least $100.00 towards my account balance with Union Physical Therapy. If there is a balance remaining at the completion of 8 visits my balance must be paid based on the schedule below or my account will be referred to a collections agency.

Balance Amount	**Payment Timeline**
$0-$1000	1 Month from completion of care
$1000-$1500	3 Months from completion of care
$1500 or more	6 Months from completion of care

_____ _____

Signature: Date:

_____ _____

Final Balance: Last Payment Expected

THIS AGREEMENT DOES NOT EXPIRE

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