PAYMENT PLAN CONSENT FORM

I, ______________________________________, consent to allow New Life Counseling to charge my past due balance according to the payment plan listed below to my (*mark one box below*):

Health Savings Account: •
Credit Card: •
Flex Card: •
Other: •_____________________________

Card Number: ______ ______ ______ ______ Exp Date: ___/____ CV code: ______

Zip Code: _________

I would like my receipts emailed to me at this email address: ____________________________

First date of payment plan:________________________________

Payment Frequency*:_____________________________________

Payment amount:____

Last date of payment: ____________________________________

*the payment plan may not exceed 18 months or past the card expiration date without a second card on file.

I understand that I may change the choice I have made at any time upon written notification to the New Life Counseling office. I will hold New Life Counseling blameless for any transactions made prior to this change of consent.

____ Date: ___/___/___
(Patient Signature)

Pleasant Hill Office
1300 Metro East Dr. Ste.106
Pleasant Hill, IA 50327
(515) 964-5003
(515) 964-3856 fax

Ankeny Office
227 NW School St.
Ankeny, IA 50023
(515) 964-5003
(515) 964-3856 fax

West Des Moines Office
1200 Valley West Dr. Ste.700
West Des Moines, IA 50266
(515) 225-4006
(515) 225-4016 fax