Yale Podiatry Group

364 East Main Street
Ansonia, CT 06401

4 Corporate Drive, Suite 384
Shelton, CT 06484

P: 203-734-4806

Dr. Luke Jeffries, DPM
Dr. Michael Travisano, DPM

Payment Arrangement Policy

Name: _____ **DOB:** _____

Auto Pay Schedule

Statement Amount: $_____

I, the undersigned, agree to authorize Ansonia Podiatry Associates, LLC to charge my CC on File (Ending in ____) according to the following Auto Pay Schedule.

Choose Payment Frequency ☐ Weekly ☐ Monthly ☐ Last Day of the Month ☐ Every 2 Weeks **Please provide email below for receipt:** _____	**Number of Payments:** _____ ☐ **Add future processed visits to this arrangement.** ★→**Additional Information** **Recurring Start Date:** _____ **Amount to be Charged:** _____

I. To cancel this arrangement, I must give a 30-day notification to Ansonia Podiatry Associates, LLC in writing and settle the remaining balance in the office.

II. If my card becomes inactive for any reason, I understand it is my responsibility to notify Ansonia Podiatry Associates, LLC and renew this arrangement with correct payment information.

III. I understand that if a payment is declined due to lack of funds, Ansonia Podiatry Associates, LLC will attempt to charge my CC on File within 10 days for the total amount that has been declined. The following payment will be charged according to the requested payment schedule as long as the account is once again current.

IV. I understand that if a payment is declined for any other reason Ansonia Podiatry Associates, LLC will make an attempt to contact me to renew this arrangement with correct payment information. If no payment is received within 30 days from this attempt, my remaining balance will be sent to a collection agency. Additional fees will be incurred at this time.

V. I understand I will no longer receive a statement for this balance, however I will receive receipts for each transaction.
   a. Statement balances can be obtained by calling the office.

By signing below, I agree to the above payment schedule and terms.

Patient Name: _____

Patient Signature: _____Date: _____

☐ MC ☐Visa ☐ Discover ☐ American Express

Expiration Date: __________ CCV: _____

Card Number: _____

Cardholder Name: _____
(As it appears on your card)

Please note:

Once this information is entered into our secure processing system all credit card information will be encrypted and the paper copy destroyed for your protection. Only the last four digits will be available for confirmation.

★Please check this box if you would like this payment arrangement to extend to any future visits that process and result in a balance. A statement will be sent out to you once any charges are added to your balance. As always your remaining balance will be reflected on your receipt after each transaction.

Minimum Payment Scale

Under $250.00……$25 monthly min

$250-$500.00…… $25-$50 monthly min

$500.00-$1000.00…… $50-$100 monthly min

$1000.00 -$2500.00……. $100-$250 monthly min

$2500.00 & Up…. Initial Deposit required, ask for more information

Office Use:

Dates of Service:

_____
_____
_____

Description of Charges:

_____
_____
_____

Notes:

_____
_____

Approved by: _____

Account #_____Wallet ID#_____