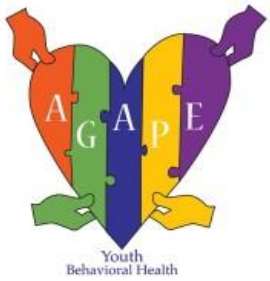

I, _____, the patient, **(Account # _____)** understand that I am agreeing to the following payment plan between myself and Agape Youth Behavioral Health. I further understand that I must sign this agreement for it to be valid. All Balances must be paid within the timeframe listed below. All unpaid Balances 30 days and older will be considered for third party collections.

I understand and agree that in addition to the agreed upon amount for this payment plan agreement that my co-payment and/or Co-insurance are due at the time of service for all Future Appointments.

In today's economic times, we understand the hardships you may be going through, Agape Youth Behavioral Health wants to work with you to resolve your balance. Payment plan agreements go up to six months and will require approval from management if additional time is needed.

In Consideration of Agape Youth Behavioral Health accepting installment payments toward Balance, you are expected to:

1. Make the payment as agreed upon without default.
2. Make Payment until outstanding balance in your account is zero dollars ($0).
3. If this agreement needs to be altered at any time or if card information needs to be updated, I will contact the Billing Department at 423-443-3336 to discuss further options.

.My current patient balance is $_____ as of _____. I further understand that if claims are still pending with insurance at the time of this agreement, you will be responsible to pay the full amount for the dates of service in addition to the amount listed above and agree to pay that amount based on this plan.

The Monthly payment will be $_____ and payment will be due on the _____ of each month.
Initials:_____

I hereby authorize Agape Youth Behavioral Health to deduct the payment amount monthly on the day indicated above from my debit/credit card.

Type of card:_____
Card Number:_____
Expiration Date:_____
Billing Zip Code:_____

Any Questions or concerns that I may have had concerning this agreement answered and/or discussed with one of the staff members at Agape Youth Behavioral Health.

Parent/Legal Guardian Printed Name:_____ Staff Printed Name:_____
Parent/Legal Guardian Signature:_____ Staff Signature:_____
Date:_____ Date:_____

Agape Youth Behavioral Health
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