CONCIERGE PAYMENT PLAN
RECURRING CHARGE AUTHORIZATION FORM

growing healthy together PEDIATRIC CLINIC

Patient Enrollment Information:

Concierge Plan Payments are to be applied to the following patients' accounts:

Name of Patient 1: _____

Name of Patient 2: _____

Name of Patient 3: _____

Name of Patient 4: _____

Recurring Charge Authorization:

Parent's Last Name: _____ First Name: _____

Billing Address Line 1: _____

Billing Address Line 2: _____

City, State: _____ Zip Code: _____

Telephone: _____ E-mail: _____

Authorization

I authorize Growing Healthy Together to charge $65 each month, ***for each patient listed above,*** to the following credit card:

☐ Visa ☐ Mastercard ☐ AmEx ☐ Other:

_____

Name As It Appears On Credit Card: _____

Credit Card Number: _____

Security Code: _____ Expiration Date: _____

Start Date for Recurring Payments (Month Day, Year)*: _____

**Credit card will be charged on this day of the month, every month, for the duration of the Concierge Payment Plan term.*

Terms and Conditions:

As the participant, I understand the scope of the services included with the Concierge Payment Plan. I agree to make the payments on the specified dates, in the agreed amounts, to Growing Healthy Together Pediatric Clinic (hereafter referred to as "GHT Kids"). If GHT Kids is unable to process payment, I will be responsible for alternate payment and any associated processing fees. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

I understand that this authorization will remain in effect until I cancel it in writing and I agree to notify Growing Healthy Together of any changes in my account information or termination of this authorization at least 30 days prior to the next billing date. GHT Kids may terminate this program agreement at any time and without any further obligation, or on 30-days-notice to you, if you fail to pay any amount due hereunder. If this program agreement is terminated due to your non-payment, there will be no refund of any portion of the program fees and fees will be owed for each month prior to termination.

I understand that the consequences of violating this contract may include, but are not limited to, my account being turned over to a collection agency; termination of participation in the program; expulsion from the practice and prosecution in small claims court. Upon default, I agree to pay all outstanding fees as well as reimburse GHT Kids for any additional costs that may be incurred during the collection process, as well as a competitive interest rate on the amount owed.

Acknowledgement:

With my signature, I acknowledge that I have read the terms of the Concierge Payment Plan agreement and attest that I understand the following:

- Monthly payments cover the cost of routine well check exams, as well as one sick visit per year.
- Vaccinations are not included with the monthly recurring payments. An additional vaccine administration fee will be charged per injection.
- Concierge program does not include any additional medical services or treatments above and beyond the scope listed above. Additional charges may apply.
- Automatic recurring monthly payments by credit card are a requirement for participation in the program.
- The initial term of the concierge program is 12 months. Patients who choose to terminate the plan early will need to pay for the remaining months, per 12 month cycle.
- Concierge program contract will automatically renew unless canceled in writing.
- If participation is terminated before the contract expires, participant may not rejoin the concierge plan at a later time.

Participant's Signature: _____ Date: _____

THIS AREA FOR OFFICE STAFF USE:

PLAN START DATE: _____ PLAN TERMINATION DATE: _____