Concierge Payment Plan

Recurring Charge Authorization Form

Patient Enrollment Information

Concierge plan payments are to be applied to the following patients' accounts:

Patient 1: _____ Patient 2: _____

Patient 3: _____ Patient 4: _____

Parent/Guardian Personal Information

Last Name: _____ First Name: _____

Billing Address: _____City, State: _____ Zip Code: _____

Telephone: (_____) _____ E-mail: _____

Terms and Conditions

I understand the scope of 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"). If GHT cannot 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 agree to notify GHT of any changes in my account information or terminate this authorization at least 30 days before the next billing date. GHT 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.

I understand that the consequences of violating this contract may include 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 and reimburse GHT for any additional costs that may be incurred during the collection process and a competitive interest rate on the amount owed.

Acknowledgment

With my signature, I acknowledge that I have read the terms of the concierge program and attest that I understand the following:

- The initial term of the concierge program is 12 months. The concierge plan contract will not automatically renew after 12 months and a new contract must be signed. If I choose to terminate the plan early, I am responsible to pay the remaining cost of my plan per 12-month cycle.
- If I change my credit card information or my card expires, I will communicate to GHT my updated credit card information.
- Monthly payments cover the cost of routine well-check exams, as well as one sick visit per year.
- Vaccinations are not included in recurring payments. An additional vaccine fee of $26.03 will be charged per injection.
- The concierge program does not include any additional medical services, testing, or treatments above and beyond the scope listed above. Additional charges may apply.
- Automatic recurring monthly payments by credit card are required for participation in the program.
- If I terminate participation before my contract expires, I may not rejoin the concierge plan later.

Signature: _____ Date: _____

I authorize Growing Healthy Together to charge **$75** each month for each patient listed to the following credit card:

☐ Visa ☐ Mastercard ☐ AmEx ☐ Other:_____

Name, As It Appears On 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.*

THIS AREA FOR OFFICE STAFF USE:

PLAN START DATE:_____PLAN TERMINATION DATE: _____