

Year One Concierge Payment Plan

Recurring Charge Authorization Form



Patient Full Name: _____ Date of Birth: _____

Parent/Guardian Personal Information

Full Name: _____ Date of Birth: _____

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

Phone: (_____) _____ E-mail: _____

Terms and Conditions

I understand the scope of services included with the Year One 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, 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, reimburse GHT for any additional collection costs, and pay a competitive interest rate on the amount owed.

I acknowledge that I have read the terms of the concierge program and attest that I understand the following:

- The term of the first year of the concierge program is 12 months. The concierge plan contract will not automatically renew after 12 months. If I choose to terminate the plan early, I am responsible for paying the remaining cost for my plan on a 12-month cycle.
- If I change my credit card information or my card expires, I will update my credit card information with GHT.
- Monthly payments cover the cost of **eight routine wellness visits**, as follows:
 - Newborn
 - 2 weeks
 - 1 month
 - 2 months
 - 4 months
 - 6 months
 - 9 months
 - 12 months
- Monthly payments cover the cost of **one sick visit**.
- Vaccinations are not included in recurring payments. A **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.
- **Attendance at all the above-listed appointments is required to stay enrolled.**
- 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 **\$99 each month** for the patient listed to the following credit card:

☐ Visa ☐ Mastercard ☐ AmEx ☐ Other: _____

Name, as it appears on the 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: _____