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PAYMENT ARRANGEMENT AGREEMENT

Date: _____

Account Number:

Account Name: _____

**Children: _____

Amount Due: _____

Promised Payment Amount: _____

Beginning Date: _____ Monthly Due Date: _____

I, _____, agree to make payments monthly as outlined above. I understand that if I am unable to make my payment by the above listed date, I will contact Piedmont Pediatrics billing department. I understand that if I am more than 5 days late with my scheduled payment, my account will be forwarded to National Credit Systems, Inc. for outside collection attempts and I am aware that a charge of \$40 will be assessed to the account. I am also aware that a charge of 1.5% of the total balance due will accrue monthly as a finance charge until the balance of my account is paid in full.

Signature: _____

Date: _____

Piedmont Pediatrics Agent: _____

Payments may be made in person at the Piedmont Pediatrics office or mailed to the above address. Please call our billing office with any questions you may have about your account.