14000 N. Portland, Suite 101
Oklahoma City, Oklahoma 73134
405.751.0011 – Phone
405.751.7246 – Facsimile

Contract and Agreement

Patient Name: ____________________________________ Date: _____________

Patient Date of Birth: _______________________

Dr. Christensen and the above-named Patient and/or Responsible Party agree to the following Terms and Conditions for payment of a past - due balance and continuing treatment by the Doctor and/or his Nurse Practitioner and/or Responsible Party.

The Patient's current outstanding balance due to this office is $___________________.

As per the Schedule set forth below, Patient and/or Responsible Party agrees and promises to make monthly payments in the amount of $_____________ beginning on the 1st day of __________________, 20________ and continuing on the 1st of each month until the outstanding balance is paid in full. The Patient agrees to provide a credit card (not a debit card) and authorize a monthly charge to credit card by the Doctor's office consistent with the payment plan.

Payment Schedule:

Balances of $300.00 or less: The payment plan shall not exceed 4 months. The Patient shall pay $75.00 a month, until paid in full.

Balances of $301.00 to $600.00: The payment plan shall not exceed 6 months. The Patient shall pay $100.00 a month, until paid in full.

Balances of $601.00 to $1,200.00: The payment plan shall not exceed 8 months. The Patient shall pay $150.00 a month, until paid in full.

Balances of $1,201.00 to $1,500.00: The payment plan shall not exceed 10 months. The Patient shall pay $150.00 a month, until paid in full.

Balances of $1,501.00 to $2,400.00: The payment plan shall not exceed 12 months. The Patient shall pay $200.00 a month, until paid in full.

Balances over $2,400.00: The payment plan shall require $300.00 per month until paid in full.

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The following terms and conditions apply to this Payment Contract and Agreement:

_______ (patient initials) The Patient agrees to provide a credit card and authorize the doctor's office to charge payment each month by the doctor's office.

_______ (patient initials) The Patient agrees to pay all costs and expenses that are due as a result of any treatment rendered after this date. In other words, in addition to paying the monthly payment set forth above, the Patient will pay all new expenses as they are incurred after receipt of the Explanation of Benefits.

_______ (patient initials) The Patient understands that failure to make a monthly payment by a valid credit card or failure to pay new expenses as they are incurred, will be a breach of this Contract and Agreement.

________ (patient initials) The Patient understands that if Patient breaches this agreement by failure to pay as set forth herein, the Doctor will immediately cease treatment of the Patient and the Physician/Patient relationship will end. The Patient will be responsible for finding a new doctor to treat Patient and/or to prescribe medications for the Patient.

________ (patient initials) The patient agrees that the Doctor's office can leave voicemails and/or text messages on patients and/or Responsible Party's answering machine and cell phone and text message.

________ (patient initials) The Patient acknowledges that Patient is given a copy of this Agreement today after it is signed by the Patient and that Patient has no questions as to the terms of this Contract and Agreement.

_________ (patient initials) The Patient has reviewed the terms of this Contract and Agreement and **declines to sign**. Patient understands that Patient must find a new Physician and Provider for treatment and medication. **Dr. Christensen will no longer be Patient's treating physician.**

Patient's Signature: ____

Today's Date: ____

Doctor's Office Representative: ___________________________________

*Please Note: If you have questions concerning your deductible expenses or out of pocket expenses or your insurance company's payment of benefits, please contact your insurance company directly. The number is located on your insurance card.