



Katahdin Valley Health Center

Patient Payment Plan Authorization for Auto Pay Agreement



I, (please print) _____ understand I am entering into a payment plan agreement with Katahdin Valley Health Center.

Starting ____/____/____, I wish to (Please check one below):

Mail/Drop off \$_____ each Month/Week (circle one and complete Option 1 below)

Debit/credit \$_____ each Month/Week (circle one and complete Option 2 below)

EFT checking \$_____ each Month/Week (circle one and complete Option 3 below)

OPTION #1 - MAIL/DROP OFF PAYMENT PLAN

By placing my signature below, I am agreeing to the above payment arrangements of amount and timing. I further agree in the event that I am unable to make a payment I will notify the billing department.

Date _____

Signature _____

OPTION #2 - CREDIT/DEBIT CARD AUTO PAY OPTION

Check one - Mastercard Visa Discover American Express

(Card Number)

V-Code (3 - 4 digits on back of card)

Expiration Date (Month & Year)

Name on Card _____

Address _____

City _____ State _____ ZIP _____

OPTION #3 - CHECK BY PHONE/CHECKING ACCOUNT DEBIT OPTION

Name(s) on Checks _____

Address _____

City _____ State _____ ZIP _____

9-Digit Routing Number

Checking Account Number

Name of Bank _____

By placing my signature below, I am agreeing to the above payment arrangements to be placed on auto-pay and debited beginning the month and day indicated above. I further agree in the event that funds are not available, I will be responsible for any charges incurred as a result of an overdraft/returned item fee.

Date _____

Signature _____