East End Primary Care
907 Lyndon Lane
Louisville KY 40222
Phone: 502-412-1904
Fax: 502-412-1905

Financial Arrangement Statement

☐ I agree to make _____ payments monthly on the 1st or 15th in the amount of $_____. If payment is unable to be made, I will call patient accounts at (**412 1904**) to inform them and discuss next payment.

☐ I authorize (practice name) to charge my credit card monthly on or about the 1st or 15th in the amount of $_____ (or less for remaining balance) for dates of service from____/____/____ to ____/____/____.

_____ _____
Cardholder signature Date

Patient Name _____

Cardholder Name _____

Cardholder Address _____

City _____ State _____ ZIP _____

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

_____
Credit Card Number Expiration Date

Financial Policy

Patient Name_____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

_____ **Patient Without Insurance (Private Pay)**
Please make payment for your care at each patient visit. If payment cannot be made at each visit, the front-desk staff will assist you in completing the form ~~on the next page~~ for financial arrangements.

_____ **We do not participate with** _____.
Please make payment for your care at each patient visit. If payment cannot be made at each visit, the front-desk staff will assist you in completing the form ~~on the next page~~ for financial arrangements.

I have read and agree to the financial policy stated above that applies to me and
I agree to the financial arrangements as outlined on the reverse side of this form.

X _____
Patient or responsible party signature Date

_____
Person signing on behalf of patient (print name) Reason patient can't sign

_____
Relationship to patient Address Phone