OCEAN MEDICINE

11 Mareblu, Ste. 200, Aliso Viejo, CA 92656
Phone: (949)446-8990 Fax: (949) 446-8535
Diagnostic Testing & Treatment for Sleep Disorders

AASM ACCREDITED Facility Member™

PAYMENT AGREEMENT

Patient Name: _____ Address: _____

Total Amount Owing: $_____

This document is to act as an agreement for an approved payment plan based upon policy set by Ocean Medicine.

The patient listed above will agree to this payment plan for the patient's outstanding account balance. Should the patient deviate from the agreed upon plan at any time (including but not limited to: missed payments, late payments, declined payments, or of a change in payment method) Ocean Medicine reserves the right to demand payment in full, unless notified by patient at least 30 days in advance. For this reason, requires the patient to complete credit card information for automatic payments to be made as outlined by the payment plan.

Ocean Medicine is confined to deduct only the minimum payment amount as agreed below using the patient's credit card information, unless otherwise informed by notification from the patient.

The patient agrees to pay $_____ per month starting _____ (date). This amount will be collected on the _____ of each month **(for a total of _____ payments)** until the patient balance is $0.00.

Please sign and return this original document with the payment information below. Signature of this document denotes that all parties agreed to the terms of this arrangement.

Ocean Medicine Representative: _____

Patient Name: _____

Date: _____

Credit Card Information to be used for Automatic Payments as Outlined Above

Credit Card Number | Expiration Date | CVV

Cardholder Name | Cell Phone#

Credit Card Delivery Address

Cardholder Signature: _____