Premier Pulmonary Critical Care & Sleep Medicine

Pulmonary Disease | Sleep Medicine | Critical Care Medicine

Payment Plan Consent Form:

By signing below, I acknowledge that I have an outstanding balance with PREMIER PULMONARY CRITICAL CARE AND SLEEP MEDICINE, PA and agree to set up a payment plan to satisfy this balance. I authorize PREMIER PULMONARY CRITICAL CARE AND SLEEP MEDICINE, PA to charge my credit/debit card in the agreed-upon monthly amount of $____ on the ___ day of each month until the balance is paid in full. I understand that it is my responsibility to ensure sufficient funds are available and to notify the office of any changes to my payment method.

Patient / Parent / Guardian Name: _____ Date: _____

Patient/ Parent / Guardian Signature: _____ Date: _____