ARBOR PSYCHIATRIC AND WELLNESS CENTER

PATIENT PAYMENT PLAN

I, _____, the patient or guarantor, understand that I am agreeing to the following payment plan between myself and Arbor Psychiatric & Wellness Center for the following patient account: _____. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe listed below. All unpaid balances 90 days or older will be considered for third party collections. In today's economic times, we understand the hardships you may be going through, and we want to work with you to resolve your balance. Listed below are our payment plan options.

Balance	Minimum Monthly Payment Amount	Minimum Bi-Weekly Payment Amount
Under $100	$40 per month	$20 bi-weekly
$101-$200	$50 per month	$25 bi-weekly
$201 - $300	$70 per month	$35 bi-weekly
$300 or above	$100 per month	$50 bi-weekly

1. My current patient account balance is $_____ as of (date) _____.
   Are claims still pending with insurance? (Check) ☐ Yes ☐ No
   I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well.
2. The monthly payment will be $_____ and payment will be due on the _____ of each month or if making bi-weekly payments those will be made the payment will be $_____ and will be made on the _____and _____of the month.
   If payment date falls on weekend or holiday, payment will be taken the next business day.
3. Should the patient or guarantor deviate from the above payment plan at any time (including but not limited to: missed payments, late payments, declined payments, or payments not made in full) Arbor Psychiatric & Wellness Center reserves the right to deny medication refill requests, cancel upcoming appointments, and send account immediately to outside collections agency. For this reason, we require the patient to file credit card information for automatic payments to be made as outlined by the payment plan.
4. Staff will attempt to contact patient or guardian via phone call if one of the following occur: payment is denied; credit card has expired; or the minimum monthly payment has increased. If no verbal confirmation is obtained, staff reserve the right to re-run a card at a later date or increase the minimum monthly payment amount.
5. I hereby authorize Arbor Psychiatric & Wellness Center to deduct the payment amount indicated above from my debit/credit card account:
   Credit Card #: _____
   Expiration Date : _____ V-Code (3 digit code) : _____
6. If this agreement needs to be altered at any time, I will contact office staff at 402-713-0110 to discuss further options.

_____ Patient or Guarantor Signature/Date

_____ APWC Staff Signature/Date

1120 6th Corso Nebraska City, NE 68410
P: 402.713.0110 | F: 402.713.0285