KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES, LLC
KC IOP
4731 S. COCHISE DR., SUITE 206
INDEPENDENCE, MO. 64055
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JOHN FRANCIS, D.O.
CHUCK FOSHEE, LCSW, LPC
BRIAN GARNER, LPC
NINA E PETERSEN, LCSW

AUTO PAYMENT PLAN AGREEMENT

DATE: _____ **PATIENT BALANCE $**_____

PATIENT NAME: _____

RESPONSIBLE PARTY NAME: _____

Street #_____ **Zip Code** _____ **Phone #** _____

By signing & returning this payment agreement, I understand that I am agreeing to make **MONTHLY**, **BI-WEEKLY OR WEEKLY** payments to Kansas City Psychiatric & Psychological Services, LLC, in lieu of my account being referred to collections.

I agree that KCPPS/KC IOP will automatically take my payment of $_____ out on or before the _____ day of each Month, Bi-Weekly or Weekly beginning in the month of _____. I also understand that if my card declines to make my Automatic Payment Plan as agreed upon that my account will automatically be turned over to collections with no further notice.

(Responsible Party Signature) **Date**

We except **Visa, MasterCard & American Express**. Please fill out the complete card information below for your Automatic Payment Plan.

MasterCard # _____ Expiration: _____
Security Code # _____ Authorized Signature: _____

Visa # _____Expiration: _____
Security Code # _____ Authorized Signature: _____

Amex # _____Expiration: _____
Security Code # _____ Authorized Signature: _____

Thank you for your attention to this matter,
Billing Department