**Payment Agreement Template**

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that I am financially responsible for payment of all services received in the amount stated below. I agree to pay that total in full in the period stated below. I understand that any remaining balance not paid in full will accrue a monthly service charge at 1.5% (minimum monthly service charge of $1). For veterinary and professional services rendered, I agree to pay ABC Animal Hospital the total sum of $

|  |  |  |
| --- | --- | --- |
| **1** | **2** | **3** |
| $ | $ | $ |
| Check: | Check: | Check: |
| Deposit: | Deposit: | Deposit: |
| Client’s Initials: | Client’s Initials: | Client’s Initials: |
|  | | |
| **4** | **5** | **6** |
| $ | $ | $ |
| Check: | Check: | Check: |
| Deposit: | Deposit: | Deposit: |
| Client’s Initials: | Client’s Initials: | Client’s Initials: |

I understand that each held check is charged a $2 service charge in lieu of the monthly service charge. I understand that if the bank should fail to honor any check held as detailed above, the entire unpaid balance shall be considered in default. The client will be charged a returned check fee of $18 for each check returned and a monthly service charge of 1.5% (minimum of $1) will be charged on the remaining balance. I also understand that if ABC Animal Hospital makes an erroneous deposit of any check listed above, that said facility will be responsible for any fees levied by the bank. I have read and understand the terms of this agreement.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Contact Information Verification** |

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ home contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ place of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s license #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I do hereby verify the above information is true and correct. I also agree to update records at ABC Animal Hospital if any of the above information changes at any time during the above payment agreement time frame.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Staff Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** Legal counsel should review your payment agreement form to ensure it complies with local, state, and federal law.