CONVENTIONS
PSYCHIATRY & COUNSELING
4300 Weaver Parkway, Suite 100-A
Warrenville, IL 60555
Phone: (630) 416-8289 Fax: (630) 416-8306

Payment Plan Agreement

I authorize Conventions Psychiatry and Counseling to keep the following credit card(s) information on file.

Primary Card Account	Secondary Card Account
_____	_____
Name on credit card (Exactly as printed)	Name on credit card (Exactly as printed)
_____	_____
_____	_____
Billing Address	Billing Address
_____	_____
Credit Card Number	Credit Card Number
_____	_____
Exp. Date CVV2#	Exp. Date CVV2#
_____	_____
Signature Date	Signature Date

I authorize Conventions Psychiatry and Counseling to charge my credit card on file for balances indicated below:

Co-payments
Coinsurance
Deductible
Office Fees- Not limited to: no-show fee, cancellation fee, prescription fee, ect.

I authorize Conventions Psychiatry and Counseling to charge $_____ on the _____ of each month, until the balance of $_____ is cleared. This authorization is valid until I provide you with written cancellation.

_____
Patient Name (Please Print)

_____
Patient/Legal Guardian Signature Date