PATIENT PAYMENT AGREEMENT

150 Lincoln Street • Lander, WY 82520 • P: 307-335-5188 • F: 307-333-0600
windriverphysicaltherapy@gmail.com • www.windrivertherapy.com

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I agree to pay for the services rendered by **Wind River Physical Therapy LLC**, as indicated below.

Payment Schedule as Follows:

Amount to be paid $_____ Weekly Bi-Weekly Monthly

Payment will be made on the _____day of each month until paid in full.

_____
_____

_____
_____

_____
_____

_____Payments will be made by cash or check

_____Payments will be made by credit card which I authorize you to use:

Name as appears on card:_____

Credit Card #:_____

Expiration Date:_____

_____VISA _____Master Card _____Discover

It is understood that if the patient misses payments, the practice will transfer account to a collection agency.

Name of Patient:_____

Name of Responsible Party:_____

Address:_____

Phone:_____

Patient/Responsible Party Signature:_____

Date signed:_____