



Hope Integrative Medicine
1064 Gardner Road, Suite 215
Charleston, SC 29407
Phone: 843.737.0312

Payment Agreement

Patient Name: _____ Date of Birth: _____

Date of Agreement: _____

Agreement Terms: This agreement is made between the undersigned patient (or guarantor) and Hope Integrative Medicine regarding the outstanding balance on the patient's account. The purpose of this agreement is to establish a repayment plan for the outstanding balance due.

1. Total Amount Due The total outstanding balance on the account as of the date of this agreement is \$_____.

2. Payment Plan Terms: The undersigned agrees to pay the balance as follows:

- **Initial Payment:** \$_____ due by _____ (date).
- **Monthly Payments:** \$_____ due on the ____ day of each month, beginning on _____ (start date) and continuing until the balance is paid in full.
- **Final Payment Amount & Due Date:** _____ (final date or upon completion of the total balance).

3. Payment Method: Payments may be made by: Cash or money order at the office or credit or debit card (for in-office or phone payments).

4. Agreement Termination: This payment agreement may be terminated by Hope Integrative Medicine if payments are not made in accordance with the terms set forth. In such an event, any unpaid balance may be subject to collections.

5. Authorization and Consent: By signing below, the undersigned acknowledges that they have read, understand, and agree to the terms of this payment agreement. The undersigned agrees to make all payments on time and as specified in this agreement until the outstanding balance is paid in full.

Patient/Guarantor Signature: _____

Date: _____

Authorized Office Representative: _____

Date: _____

I understand that my medical record may contain sensitive information regarding mental health, drug or alcohol abuse, HIV/AIDS status, or other confidential information. With this understanding, I hereby waive any right to confidentiality arising under South Carolina law and authorize the release of records of information, but only the extent specified below.

I authorize **Hope Integrative Medicine** to release and/or receive the following information:

- ☐ All Medical Records
- ☐ Diagnosis
- ☐ Presence/Participation in Treatment
- ☐ Other:

The above information is only to be released to, and/or from, the following party:

Name and/or Agency	Address	City, State, Zip	Fax or Email
--------------------	---------	------------------	--------------

This information is to be used for the purpose of continuity of care.

This authorization shall remain in effect for 1 year at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I hereby release the parties named above from any liabilities for release of this information.

Patient Signature: _____ Date: _____