SEIFERT & ASSOCIATES
30/60/90 DAY EXTENDED PAYMENT PLAN

Agreement of extended Payment Plan to Seifert & Associates

Patient Name: _____
Address : _____
City:_____ **State:**_____ **Zip-code:**_____
Telephone/Home : _____ **Work/Cell:** _____
Credit Card : MC VISA AMEX DISC DEBIT Exp. Dt.: _____

I hereby accept the Extended Payment Plan outlined below and agree to make payments as scheduled. I understand that if I fail to make these payments when due, after the initial 10 day grace period my account or credit card will be charged for the payment # Amt. Due. If the credit card is not authorized, my account will be turned over to a collection agency, in which case I will be obligated to pay the costs of collection, court, and legal fees in addition to the balance owed to Seifert & Associates. No interest will be charged.

Total Cost of Professional Fees & Material Fees: $_____
Less 1st -1/3 Payment: (to place order/Deposit Fee): $ _____
Less 2nd -1/3 Payment: (to pick-up glasses): $ _____

Total Loan Balance $ _____

Payment #1 amount $ _____ **Due** _____
Payment #2 amount $ _____ **Due** _____
Payment #3 amount $ _____ **Due** _____

Patient Signature: _____ **Date:** _____

Authorized by: _____ **Date:** _____

Payment Coupons:
(cut on dotted line and mail payment with check, money order, or credit card number to: Seifert & Associates, 4 Springville Rd. Hampton Bays, NY. 11946. Please make checks or money orders payable to Dr. Glenn A. Seifert.)

Payment # 3

Patient's Name: _____ **Payment must be received by:** _____

Payment Due: $ _____ **Amount Enclosed: $** _____

Payment # 2
Patient's Name: _____ **Payment must be received by :** _____

Payment Due: $ _____ **Amount Enclosed: $** _____

Payment # 1

Patient's Name: _____ **Payment must be receive by:** _____

Payment Due: $ **Amount Enclosed: $**