

**Payment Plan Receipt**  
**SELECT PAIN PROCEDURE CENTERS**

SWISS AVENUE SURGICENTER, L.P.

7920 Beltline Road, Ste 940,  
Dallas, TX 75254  
Ph# 972 234 4740 : : Fax# 972-231-7095

Date: 01/05/2015 Time: 04:42 PM CST

Patient Account Number: 101011  
Patient Name: ROBERT PLOCK  
Dates of Service Provided:  
Invoice Date: 07/03/2013  
Cardholder Name: ROBERT PLOCK

Payment Date	Payment Amount	Remaining Balance
		\$754.90
02/01/2015	\$50.00	\$704.90
03/01/2015	\$50.00	\$654.90
04/01/2015	\$50.00	\$604.90
05/01/2015	\$50.00	\$554.90
06/01/2015	\$50.00	\$504.90
07/01/2015	\$50.00	\$454.90
08/01/2015	\$50.00	\$404.90
09/01/2015	\$50.00	\$354.90
10/01/2015	\$50.00	\$304.90
11/01/2015	\$50.00	\$254.90
12/01/2015	\$50.00	\$204.90
01/01/2016	\$50.00	\$154.90
02/01/2016	\$50.00	\$104.90
03/01/2016	\$50.00	\$54.90
04/01/2016	\$50.00	\$4.90
05/01/2016	\$4.90	\$0.00

I (we), the undersigned, authorize and request Select Pain Centers to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Select Pain Centers.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Select Pain Centers in writing and the account must be in good standing.

Patient Name (Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Authorization</b> I hereby authorize the electronic withdrawal of funds from my account in the increments specified above on each Payment's Due Date.
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Signature: \_\_\_\_\_