

## Dave's Test Subscription

test subscription address  
Dallas, PA  
(888) 306-1256

**Care Summary for: Joe Boon**

**10/15/2008**

### CarePlan

Provider:	Doogie Houser, DC
Number:	000041
Type:	Acute
Start Date:	10/15/2008
Estimated End Date:	1/7/2009
Estimated Number of Visits:	48-50

### Hardship Discount

The Patient is not eligible for a Hardship Discount  
Discount Percentage Approved: N/A  
Estimated Hardship Discount Amount: 0.00

### Basic Assumptions

Work-Accident: Care will not be subject to Workers' Comp laws  
Direct Pay:  
Payer(s) will pay the office directly at the following percentage of Total Charges: 100%  
Deductible: \$500.00 Copay: \$10.00 Visits Limit: N/A Co-Insurance: 0% Dollar Cap: \$0.00

### Estimates

Total Estimated Charges:	\$3,600.00
Total Estimated Insurance Payments:	\$1,326.34
Total Estimated Discounts:	\$1,418.66
Total Estimated Patient Responsibility to Office:	\$855.00

### Payment Plan

Schedule Type:	Auto-Draft-- Equal Payments
Payment Due Days:	Each Month, on the 1st, 15th
Duration of Payment Plan:	Until the CarePlan ends
Scheduled Draft Amount:	\$142.50
Payment Method:	Mastercard (Credit Card) ends with 4390

*The amount of the Auto-Draft is based on a schedule of equal installment payments. Auto-Draft is applied to the credit / debit card on file.*

### Terms and Conditions

This Payment Plan includes various estimated amounts prepared by our Office and reflects subjective views. They are based in part on interpretations of factors and on forecasts and projections of future conditions. Other persons could reasonably disagree with these estimated amounts. We make no representation that actual results will conform to the estimates. These estimated amounts are subject to change at any time based on circumstances beyond our control. We reserve the right to adjust the amount of any remaining payments, including increasing said amounts, to account for such changes.

You may discontinue care at our Office for any reason. In the event that care is discontinued, you will not be penalized in any fashion. Any unpaid balance associated with care which has actually been rendered shall continue to be payable (a) regardless of the results of care and (b) according to the previously scheduled payments and due dates until the unpaid balance is paid in-full. In the event that you miss a scheduled payment, the Office reserves the right to immediately collect in-full the remaining balance owing to the office and to charge your credit card accordingly without any further notice to you. In the event of a pre-payment, the following terms shall apply: (1) pre-payments shall be construed as credit balances only; (2) any unapplied or unused portion of the credit balance shall be refunded to you within thirty (30) days upon request; and (3) pre-payments shall not be construed, or relied upon by you, as either insurance, Health Savings Account, Health Discount Plan, any form of Trust, or as any type of plan which might create a fiduciary duty by our Office to you.

You represent that you are an authorized signor on the above-reference credit card and authorize us to charge your card consistent with this Payment Plan.

\_\_\_\_\_  
(Signature of Patient)

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(Date Signed)