GIBSON™ DIAGNOSTIC LABS
813 N. O'Connor Rd. | T: 855.890.9581 | CLIA # 45D2095863
Irving, TX 75061 | F: 800.435.4057 | www.gibsondx.com

PAYMENT PLAN AGREEMENT

Date _____

This Payment Plan Agreement (this "Agreement") is entered into by Gibson Diagnostic Labs, LLC ("GDL") and _____ ("Patient").

_____
Account Number(s) (Required)

Patient's physician ordered clinical diagnostic test(s) for Patient. As a result, Patient has an outstanding balance in the amount of **$** _____ due to GDL.

Patient certifies that payment of this amount in full would be a financial hardship for Patient, and therefore, Patient is entering into this Agreement in order to set up a payment plan for the outstanding amount owed to GDL.

In consideration of Patient agreeing to make payments as set forth below, GDL agrees to not send Patient's account to collections and to not charge interest on the outstanding amount due and owed to GDL, as long as the terms of this Agreement are being met.

Patient agrees to pay the amount of $ _____ (Minimum $100) monthly and will be due by the first (1st) day of the month until the balance is paid in full, commencing on _____ , 20____, and ending on _____ , 20____.

I hereby authorize GDL to charge the amount indicated above to the following debit/credit card account, during the term referenced:

TYPE OF CARD ☐ Mastercard ☐ Visa ☐ Amex ☐ Discover

_____ _____ _____
Credit Card Number | Expiration Date | Billing ZIP

No modification, amendment or addition to this Agreement shall be valid or enforceable unless in writing and signed by both parties.

Agreed and Accepted: _____
Patient Signature (or Patient's Representative)

Submit this signed agreement to Gibson Diagnostic Labs Patient Billing Department - Email: billing@gibsondx.com