Arctic Physical Therapy Services
813 Lower Mill Bay Rd. Kodiak, AK 99615
P(907)486-4499 F(907)486-8211
arcticpt@gmail.com

Payment Plan

Patient Name: _____

Date: _____

Monthly payment amount: $_____

Payment due on _____ day of the month.

Payments will be made by check ___or cash ___

Please process my monthly payment on a debit ___ or credit card ___

Credit Card number: _____

Card Expiration:_____ CVV Code: _____

Balance: _____

If my payments are not made on the day that was chosen, I understand my account will be turned over to a collection agency. If my payments will be made by credit card, I authorize Arctic Physical Therapy Services, Inc. to process monthly payments from my credit card until my balance is zero.

_____ _____

Patient/Guarantor Signature Clinic Representative