APEX PEDIATRIC THERAPY SERVICES
Phone: (847) 376 9191; Fax: (847) 589 5875
info@apexped.com; www.apexped.com

PAYMENT CONTRACT FOR SERVICES

Name(s): _____

Address: _____ City: _____ State: ____ Zip: _____

Bill to: Person responsible for payment of account: _____

Address: _____ City: _____ State: ____ Zip: _____

Part One: Fees for Professional Services

I (we) agree to pay APEX PEDIATRIC THRAPY SERVICES LLC, any co-pay, co-insurance or deductible amount due to them for the services provided as per our health plan.

Payments are due in 30 days from the date of invoice.

I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ___/___/____