



Club Spectrum ABA

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Orlando, FL
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Co-Pay/Payment Plan Agreement

I understand that per my agreement with my insurance company, _____, as well as with Club Spectrum ABA, Inc, the provider of services, that I am responsible for paying a copay for services rendered. Payment is due in full at time of service or upon receipt of a monthly bill from Club Spectrum ABA, Inc. In the case of financial hardship, Club Spectrum ABA, Inc. agrees to develop a payment plan to ease the financial burden.

I, _____, agree to pay Club Spectrum ABA \$_____ per month until the entire copay bill is satisfied. Termination of services does not void the outstanding amount and I understand I will continue to make payments until the bill is paid in full.

Club Spectrum ABA, Inc. agrees to bill _____ in a timely manner and keep a running account of payment owed. Failure to make payments two months in a row without an amendment to this agreement will result in termination of services. I, _____, agree that Club Spectrum ABA, Inc. will continue to bill me until the full amount is satisfied.

Client/Guardian Name

Client/ Guardian Signature Date

Club Spectrum ABA Representative signature Date