Medcerts
14143 Farmington Road
Livonia, MI 48154
877-587-5339
Studentpaymentservice@medcerts.com

PAYMENT PLAN AGREEMENT

This Payment Plan Agreement - **Plan ID# 92DD9AEF-A5DTUE1P** ("**Payment Plan Agreement**") is between **Student Payments - MedCerts** and **TEST O'TEST** and is effective **August 26, 2022** ("**Effective Date**").

Purchased Goods and Services

Claim Number	Encounter ID	Date of Service	Description	Amount Owed
				$1.00
Total				**$1.00**

Federal Truth-in-Lending Disclosure

Annual Percentage Rate	**The cost of your credit as a yearly rate. APR calculates the total cost of the loan and includes any other fees.**	**0.00%**
Finance Charge	**The dollar amount the credit will cost you.**	**$0.00**
Amount Financed	The amount of credit provided to you or on your behalf.	$1.00
Total of Payments	The amount you will have paid when you have made all scheduled payments.	$1.00
Total Sale Price	Total price of your purchase on credit, including any down payment.	$1.00

Itemization of Amount Financed

Bill Amount	$1.00
Down Payment	$0.00
Amount Financed	$1.00
Finance Charges	
One-time Setup Fee	$0.00
Interest	$0.00
Total	**$0.00**
Interest Rate	0.00%

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Payment Plan Agreement Details			
0 Payments of	$0.00	Scheduled Payment Day	1st
Total Number of Payments	0	Next Scheduled Payment Date	
Payment Frequency	Monthly	Last Scheduled Payment Date	
Term (in Months)			

Late Fee: I acknowledge that if all or any portion of a payment is not paid within ten (10) days of its due date, I will be charged a late fee of **$30.00**.

Prepayment: I acknowledge that if I pay off this agreement early, I will not have to pay a penalty.

See Terms and Conditions below for additional information about nonpayment and default.

Terms And Conditions

Return Fee: I acknowledge that if any check, draft, credit card or order is returned or declined for any reason without limitation including insufficient funds, I will be charged an additional return fee of **$20.00**.

I acknowledge that I can terminate my treatment plan at any time and, subject to applicable law, that I will be responsible only for those services provided to me and any non-refundable products, supplements or prescriptions.

I acknowledge that my provider has contracted with ClearGage, LLC to act as its service provider and/or administrator of this payment agreement. Please contact customer service at (877) 587-5339 for any questions about your payment plan.

I acknowledge that my provider may assign, transfer, sell or pledge this Agreement to any third party at anytime.

Electronic Consent and Communications Terms

☐ I hereby confirm my Electronic Consent and Communication Preferences.

Payment Authorization

☐ I further understand and agree that My authorization for automatic payments and storage of My Payment Method will remain in full force and effect until revoked by Me, My financial institution, or **Student Payments - MedCerts**. I may revoke My authorization by calling (877) 587-5339, which revocation will be effective when **Student Payments - MedCerts** has had a reasonable opportunity to act on it. If I revoke My authorization, or if **Student Payments - MedCerts** or My financial institution cannot process My automatic payment, I understand and acknowledge that I will remain responsible for paying My payments, including by making payments on or before the due date on each bill.

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Acceptance of Agreement

Do not sign this Payment Plan Agreement before you read it or if it contains blank spaces.

You will be provided an exact copy of this Payment Plan Agreement upon signature.

I promise to pay **Student Payments - MedCerts** the principle amount of **$1.00** plus interest at a fixed rate of **0.00%** per year on the unpaid balance from the date of this Agreement until maturity. I further acknowledge and agree should any payment obligation under this Agreement become more than sixty (60) days late, to the extent not prohibited by applicable law, **Student Payments - MedCerts** may declare me in "default" and demand immediate payment of the entire remaining balance, or debit my primary or alternate payment account for the full balance owed. I acknowledge and agree that should a default occur, to the extent not prohibited by applicable law, I will be obligated to pay **Student Payments - MedCerts** for additional charges related to the costs of collection, including, without limitation, collection agency fees, court costs, and attorney's fees.

☐ I hereby acknowledge and accept the terms and conditions herein and agree to enter into this Payment Plan Agreement as of the Effective Date.

Patient Signature _____

Provider Signature _____