AFFINITY™
PHYSICIAN NETWORK

TCore20™ Patient Program Payment Form

The undersigned acknowledges that he/she has voluntarily sought and received valuable medical consultation, services and/or products through Affinity Physician Network ("APN"). The undersigned authorizes APN to collect amounts relating to such consultation, services, and/or products as set forth herein.

Provider Name: _____

Patient Name: _____

☐ **Charge Patient Directly**
**If selected, please complete below with all patient payment information and signature*

☐ **Charge Provider Office**
**If selected, no need to complete below. Provider's card on file will be charged agreed upon Provider cost*

☐ **Payment Plan:**

Order Amount: $_____

☐ **Pay-In-Full:**

Order Amount: $_____

Finance Fee: $45.00 (Forty-Five Dollars)

Financed Order Total: $_____

30% Down Payment: $_____ *charged immediately

Financed Amount: $_____

Monthly Payment (Financed Amount ÷ 4): $_____

1st Payment Date: _____ *charged 30 days from order date

Payment(s) will be made by (select one): ☐ credit/debit card ☐ HSA card

Patient's Card Information:

Type: _____ Name on Card: _____

Card #: _____ Exp: _____ CVV: _____

The undersigned acknowledges this is a binding and enforceable Payment Agreement for health care consultation, services and/or products, and the undersigned also acknowledges having received full disclosure of the TCore20™ Program as well as the necessary commitment to follow TCore20™ Program guidelines in order to give rise to results ("Agreement"). With respect to the foregoing payment terms and obligations, the undersigned fully authorizes APN to charge his/her Credit Card or Bank Account for all amounts due and payable under this Agreement. Any overdue balances will bear interest at the rate of 12% per annum. By signing below, Patient agrees to the enforceabilityof this Agreement and all terms and conditions.

_____ _____
Signature Date