



Advanced Counseling and Testing Solutions, LLC

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Payment Plan Agreement

I, _____, agree to enter into a payment plan with Advanced Counseling and Testing Solutions, LLC. to manage the outstanding balance on my account. I understand that I must keep an updated credit card on file for monthly payments. I understand that should I fail to meet the terms of this agreement, my account will be sent to collections or small claims court.

Beginning Balance Owed: \$_____

Payment Date	Payment Amount	Remaining Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read, fully understand, and agree to the conditions of this Payment Plan Agreement. If I have any questions regarding this agreement, or my account, I will contact Advanced Counseling and Testing Solutions, LLC. immediately for assistance.

Signature of Client/Representative/Legal Guardian

Date

Signature of Practice Administrator/Billing Specialist

Date