



# Payment Plan Agreement

REVISED 09/15/2020

PATIENT NAME: \_\_\_\_\_

RESPONSIBLE PARTY NAME: \_\_\_\_\_

PATIENT ACCOUNT NO: \_\_\_\_\_

LAST DATE OF SERVICE: \_\_\_\_\_

BALANCE DUE ON ACCOUNT: \$ \_\_\_\_\_

PAYMENT AMOUNT: \$ \_\_\_\_\_  WEEKLY  MONTHLY

FIRST PAYMENT DUE ON/BEFORE: \_\_\_\_\_ TO AVOID FURTHER ACTION ON YOUR ACCOUNT.

\*\*30 days from Payment Agreement Form signature date\*\*

*\*\*I hereby agree to this payment agreement schedule for charges incurred at Partnership Health Center until my account balance is paid in full. I understand that I must make my nominal fee payments on the dates of service in addition to my monthly payment toward my past due balance. My failure to make payments without notification to the Billing Department at Partnership Health Center may result in further collection action on your account balance. Partnership Health Center will have full discretion for unpaid accounts and will take necessary action to collect any unpaid balances.\*\**

*\*\*I also hereby acknowledge that this payment agreement does not include any balance I may owe in the Pharmacy and I understand that I will be required to establish a separate payment agreement for any balance due with the Pharmacy.\*\**

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PHC Staff Member Signature

\_\_\_\_\_  
Date