PHC PARTNERSHIP HEALTH CENTER

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