Pharmacy Payment Plan Agreement

REVISED 09/15/2020

PATIENT NAME _____

RESPONSIBLE PARTY NAME: _____

PATIENT ACCOUNT NO: _____P *(MEDICAL ACCT # W/ A P AT THE END)*

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 Clinic (Medical, Dental, & Behavioral Health Services, ect.). I understand that I will be required to establish a separate payment agreement for any balance due with the Clinic. ***

_____ _____

Patient or Responsible Party Signature Date

_____ _____

PHC Staff Member Signature Date