

## 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 FURT	THER ACTION ON YOUR ACCOUNT
**30 days from Payment Agreement Form sig	gnature date**
** I hereby agree to this payment agreement schedule for characteristic descriptions and the dates of service in addition to make payments on the dates of service in addition to make payments without notificat Partnership Health Center may result in further collection and Partnership Health Center will have full discretion for unpaid action to collect any unpaid balances. **  ** I also hereby acknowledge that this payment agreement do may owe in the Clinic (Medical, Dental, & Behavioral Health Serwill be required to establish a separate payment agreement for Clinic. **	stand that I must make my by monthly payment toward my cation to the Billing Department ction on your account balance. Eccounts and will take necessary pes not include any balance I cvices, ect.). I understand that I
Patient or Responsible Party Signature	Date
PHC Staff Member Signature	 Date