Family Health Care Center

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Patient Payment Plan

I, ____________________, the patient, (Account#__________) understand that I am agreeing to the following payment plan between myself and Family Health Care Center. I further understand that for the following payment plan to be valid I must sign this document. All balances must be paid within the timeframe listed below. All unpaid balances thirty days or older will be considered for collections.

We understand that you may not be able to make payment in full on an account due to financial hardships, and in order to work with you to resolve your account balance we have developed the following payment plan guidelines:

1.) My current account balance is $__________ as of ____________.

Are claims still pending with insurance? Yes No

I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the current balance indicated above, and further more agree to pay that amount based on this plan as well.

2.) The monthly payment will be deducted on the 1st or 15th of each month, unless otherwise specified.

3.) I hereby authorize Family Health Care Center to deduct $ __________ monthly on the day indicated above from my debit/credit card.

Type of Card: MasterCard Visa American Express Discover
Card #:____
Expiration Date: ______________
Billing Zip Code: ______________

4.) Any questions or concerns regarding this agreement were answered or discussed by one of the staff members at Family Health Care Center. If circumstances arise that indicate a need to review the agreed upon terms, or where payment authorization must be revoked, the request to terminate the payment plan must be received by Family Health Care Center in writing. Any payment plan that deviates from payment plan policy must be approved by a member of the Family Health Care Center management team with their initials documented on the payment plan. Patient understands that refusing payment plan terms, or any denied payments could result in revocation of appointment privileges, and result in account balances being turned over to collections.

_____________________________ _____________________________
Patient/Guarantor Printed Name Patient/Guarantor Signature

_____________________________ _____________________________
Date FHCC Staff Signature