

# OUR COMMUNITY HEALTH CENTER

## PAYMENT AGREEMENT

PATIENT NAME: John Doe

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

PATIENT ACCOUNT NO: 76514354

LAST DATE OF SERVICE: 1/10/2015

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

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

I hereby agree to this payment agreement schedule for charges incurred at Our Community Health Center until my account balance is paid in full. My failure to make payments without notification to the Billing Department at Our Community Health Center may result in further collection action. Community Health Center will have full discretion for unpaid accounts and will take necessary action to collect any unpaid balances.

_____	_____
Patient or Responsible Party Signature	Date

_____	_____
OCHC Staff Member Signature	Date