OUR COMMUNITY HEALTH CENTER

PAYMENT AGREEMENT

PATIENT NAME:_____

RESPONSIBLE PARTY NAME:_____

PATIENT ACCOUNT NO:_____

LAST DATE OF SERVICE: _____

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