PATIENT PAYMENT PLAN REQUEST

Requested By: DOB:

Address:

Address must be present for accounts payable to process request.

I ____________________ have been notified of a repayment amount. I agree to repay in ___ number of payments in the amount of $__________ for a total repayment of $ __________. First payment is due __________ with the balance due by __________.

Patient Signature: ____________________________ Date: ___________________________

Standard Repayment Schedule:

Balance	Payment Amount	# of Payments	Max Time
> $50.00	Full payment	1	At time of service
$50.01-100.00	½ balance	2	30 days
$100.01-200.00	¼ balance	4	90 days
>$200.00	10%	10	10 months

Purpose: This form is used when it is necessary to have a payment plan established. This is the only form which will be accepted for a patient payment plan.

Procedure: Complete this form, attach patient account record, submit it to the Business Office Manager and Administrator for approval, and forward to staff accountant for processing.

Approvals:

_____________________________________ _____________________________

Billing & Insurance Manager Date

_____________________________________ _____________________________

Administrator Signature Date

_____________________________________ _____________________________

Managing Partner Signature Date