Pullman Regional Hospital Clinic Network LLC
Payment Plan Agreement Contract

It is the policy of PRH Clinic Network to gather all outstanding balances on accounts before a patient is seen in the office. However, we understand that patients may be in situations that require them to make payments on their accounts in order to pay off the balance. Therefore, we are willing to extend the following payment plan agreement to you.

I _____, agree to remit payments

to PRH Clinic Network LLC under the terms laid out below.

Names and account numbers of patient accounts covered under this agreement:

_____ _____

_____ _____

Current balance of all accounts listed above _____

Total months needed to pay the balance off _____

Monthly payment plan amount _____

Date of first payment _____

Amount of first payment _____

I understand that failure to make my agreed monthly payment in the amount stated above may result in placement into a collection agency and I agree to pay a collection fee of $25.00.

I understand that should the balance on my account increase due to additional visits being added to my current balance, Pullman Regional Hospital Clinic Network may reassess my account at any time and request that I renew or change my Payment Plan Agreement.

I understand that Payments must be made by the last day of each month in order to keep my account current.

Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to Patient**_____

Employee Witness: _____ **Date:**_____