Family Center for Health Care
At Citizens Health

310 East College Drive
Colby, KS 67701

Tel: (785)462-6184 / Fax: (785)460-1490
www.cmciks.com

PAYMENT ARRANGEMENT AGREEMENT

Thank you for choosing Family Center for Health Care for your family's health care needs. We are always willing to work with individuals as they try to manage their financial responsibilities for their clinic accounts. The purpose of this form is to set your account up on a monthly payment plan agreed upon by yourself and the clinic.

You are responsible for making a payment each month to keep your account current. If you are unable to make your monthly payment, you must contact the clinic ahead of time and make us aware of your situation. Failure to do so will result in a delinquent account balance. *Note: If your account was in pre-collections on the date you signed this form, it is vital you make your monthly payments to avoid being sent to collections. Should your account again become delinquent with two consecutive missed monthly payments, and no communication on your part to remedy the situation, your account will be sent to collections immediately following the second missed payment.*

Account Guarantor: _____

Patient Names on Account: _____

My current total account balance is $ _____.
My account is in pre-collections: ☐Yes ☐No

I agree to make monthly payments of $_____,

by the (day) _____ of each month (ex: 1st, 10th, 15th, etc.).

Please select one:
☐ My first payment will be made by (date)_____, or

☐ My first payment of$_____ is enclosed.

By signing this agreement, you are pledging to make your required monthly payments as described above. Thank you for resolution of your account.

_____ _____
Name (Print) Phone Number/s

_____ _____
Signature Date

"Our Family Taking Care of Your Family"