FAMILY AND MEDICAL COUNSELING SERVICE, INC

PAYMENT AGREEMENT

PATIENT NAME: _____

DOB: _____ Date of Service: _____

PATIENT ACCOUNT NO: _____

PATIENT COPAY/ACCOUNT BALANCE: $_____

PAYMENT AMOUNT RECEIVED: $_____

NEXT PAYMENT DUE IN THE AMOUNT: $_____ DATE: _____

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

_____ _____

Patient or Responsible Party Signature Date

_____ _____

FMCS Staff Member Signature Date