

HEALTHCARE ON THE SQUARE

Boydton Community Health Facility, Inc.
380 Washington Street
Boydton, Virginia 23917
P: 434-738-6102 ext 108
F: 434-738-6982

PAYMENT PLAN AGREEMENT

Date _____ Chart # _____ Account # _____

Name _____ Balance \$ _____

1. I/We owe and promise to pay Boydton Community Health Facility the sum of \$ _____ in weekly, bi-weekly or monthly installments of \$ _____.

Monthly installments:

The first installment is due and payable on or before the _____ day of _____ (include month and year) and an installment to become due and payable on the same day of each succeeding month until all said installments are paid in full.

Bi-Weekly Installments:

The first installment is due and payable on or before the _____ day of _____ (include month and year.) The remaining installments will become due or payable on or before the 15th and the 30th of each succeeding month until all said installments are paid in full.

Weekly Installments:

The first installment is due and payable on or before the _____ day of _____ (include month and year) and an installment will become due on _____ (indicate day of the week), on same day of the succeeding weeks until all said installments are paid in full.

2. I understand that I may continue to receive services during my re-payment period on a **CASH ONLY BASIS** to avoid increasing the amount of outstanding debt.

3. **This agreement must be kept. If payment is not received as promised, this agreement will become invalid and your account will be turned over to an outside collection agency. I understand that if this agreement becomes null and void Boydton Community Health Facility will no longer be able to provide me/us with services until the outstanding amount is satisfied.**

4. In the event legal action becomes necessary regarding the collection of this note, I/We understand that we will be liable for all amounts which may be due under this contract, including but not limited to a reasonable interest charges, court cost, and attorney fees required by Boydton Community Health Facility to collect this bill.

First Payment Due: _____ Payment Amount: \$ _____

Patient/Responsible Party Signature: _____ Today's Date _____

Current Address: _____

Telephone #: _____ SS #: _____

Employer's Name: _____

Witness: _____ Today's Date: _____

Other: _____
