Payment agreement

Account Number _____ **Date of Service** _____

I, _____, enter into a payment agreement with the Pend Oreille Surgery Center LLC for charges incurred for my procedure(s). I agree to make payments, according to the following schedule, on the total estimated amount due of $_____.

– Due Date –	**– Amount Due –**
Down payment	$_____ Paid
_____	$_____ Paid
_____	$_____ Paid
_____	$_____ Paid

I understand that these charges are related to the facility only. In the event additional procedures are performed or extraordinary supplies are used, I understand I will be responsible for these charges as well and these charges will affect the amount of my payments. The Surgery Center will inform me of any extraordinary charges via the detailed initial statement.

My failure to comply with the payment terms of this agreement will result in my account being sent to a collection agency 5 (five) days after a default has occurred.

_____ _____ _____
Printed Name Signature Date

_____ _____
Business Director/Authorized Personell Date

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