Family Health Care Center

23702 Hwy 80 East, Statesboro, GA 30461

Patient Payment Plan

I, _____, the patient, (Account # _____) understand that I am agreeing to the following payment plan between myself and Family Health Care Center. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. In today's economic times, we understand the hardships you may be going through, and we want to work with you to resolve your balance. Listed below are our payment plan options.

Payment Plan

Balance	Minimum Payment Amount
Under $100	$25 per month
$100 - $200	$35 per month
$201 - $300	$45 per month
$300 or above	$50 per month

2. My current patient account balance is $_____ as of (date) _____.

   Are claims still pending with insurance? (Circle) Yes No

   I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well. Patient's (or Guarantor's) Initials _____

3. The monthly payment will be $_____ and payment will be due on the _____ of each month.

4. I hereby authorize Family Health Care Center to deduct the payment amount monthly on the day indicated above from my debit/credit card account:

   Type of Card (Circle): Mastercard Visa American Express Discover

   Account #: _____
   Expiration Date: _____ V-Code (3 digit security code): _____
   Billing Address Street #: _____ Billing Zip Code: _____

5. Any questions or concerns that I may have had concerning this agreement were answered or discussed with one of the staff members at Family Health Care Center. If this agreement needs to be altered at any time, I will contact the Office Manager, Brandi Waters, at 912-489-4090 ext. 23 to discuss further options. Patient's (or Guarantor's) Initials _____

_____ _____
Patient or Guarantor Printed Name Patient or Guarantor Signature

_____ _____
Date Witness: Staff of FHCC Signature