MONTHLY PAYMENT AGREEMENT

DATE_____ ACCOUNT #_____

PATIENT NAME_____

RESPONSIBLE PARTY_____

RELATIONSHIP TO PATIENT_____

RESPONSIBLE PARTY ADDRESS_____

_____

RESPONSIBLE PARTY PHONE # _____

This is a monthly payment agreement between Conway Orthopaedic & Sports Medicine Clinic (COSMC) and the above responsible party. The responsible party agrees to pay $_____ each month until the above mentioned account is paid in full.

Minimum monthly payments are set at $100. All patient account balances must be paid in full within 1 year from the date entered above. If at any time the patient account balance exceeds $1,000, either COSMC or the responsible party may request the monthly payment agreement be reviewed for other payment options.

Payments will be received by COSMC on or before the ____ of each month, with the initial payment of $ _____ being made on_____. If the agreed payments are not made and received timely, COSMC shall, at its option, declare this agreement breached and pursue further action that may include submission to an outside collection service and/or legal remedies.

By signing below, the responsible party acknowledges he/she has read and understands this agreement, and they are personally responsible and liable to COSMC for payment in full of the account balance of the account number listed above according to the terms of this agreement.

RESPONSIBLE PARTY SIGNATURE _____

ADDITIONAL COMMENTS _____

_____

COSMC REPRESENTATIVE SIGNATURE_____

(6/2010)