## OUR COMMUNITY HEALTH CENTER

## PAYMENT AGREEMENT

PATIENT NAME:	
RESPONSIBLE PARTY NAME:	
PATIENT ACCOUNT NO:	
LAST DATE OF SERVICE:	<u></u>
BALANCE DUE ON ACCOUNT: \$	
PAYMENT AMOUNT: \$	WEEKLY / MONTHLY
Community Health Center until my according payments without notification to the B. Center may result in further collection according to the content of the c	ment schedule for charges incurred at Our ant balance is paid in full. My failure to make illing Department at Our Community Health tion. Community Health Center will have full take necessary action to collect any unpaid
Patient or Responsible Party Signature	Date
OCHC Staff Member Signature	Date