

Ambulance Service Payment Plan Contract

In consideration of the ambulance service provided on the following dates and for the following amounts:

Patient	Date of Service	Balance Owed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total		_____

I hereby agree to the following payment arrangement:

I, _____, promise to make monthly payments in the amount of \$_____ due on the _____ day of each month beginning on _____ and continuing on the same day of each month thereafter until the balance is paid in full.

I realize that my failure to make any scheduled payment as promised will result in my account being placed for collection and will result in the full balance being due and payable. If I know that I will not be able to make a payment as scheduled and to avoid further collection procedures, I may contact the ambulance service billing office prior to the due date of the scheduled payment for alternate payment arrangements. However, I realize the billing office reserves the right to approve or disapprove any unreasonable alternate payment arrangement.

By signing below, I hereby agree to the terms stated above.

Patient/Guarantor Signature

Date

Billing Office Representative

Date