Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center • Wilson Community Health Center

Monthly Payment Plan Agreement

____ Carolina Family Dental Center 252-443-7764

____ Freedom Hill Community Health Center 252-641-0514

____ Harvest Family Health Center 252-443-7744

____ Wilson Community Health Center 252-243-9800

Effective Date: _____

Patient MRN: _____

Balance Due: $ _____

Monthly Payment: $_____

Credit/Debit Card #: _____ EXP: _____ CVV#: _____

ACH: Bank Institution: _____ Routing#: _____ Account#: _____

I agree to pay Carolina Family Health Centers, Inc. (CFHC) monthly installments until my account balance is cleared. I understand the payment plan will be revised to reflect additional charges incurred for future visits made to CFHC during the payment plan cycle.

I agree to allow CFHC access to my financial information for the sole purpose of processing the recurring payments outlined in this agreement.

I understand that if I fail to make my monthly payments as outlined in this agreement, I will be subject to the collection processes of CFHC.

_____ _____

Patient or Guarantor's Signature *Date*

_____ _____

Staff Signature *Date*

Payment Plan Guidelines

Patient Balance	*Minimum Payment*
$50 - $199	$20
$200 - $299	$25
$300 - $399	$35
$400 - $499	$40
$500 & Over	$50