



ALGONE ANC
INTERVENTIONAL PAIN

9500 Independence Drive, Suite 700,
Anchorage, Alaska 99507
Phone: 907 770 1152
Fax: 907 770 1153

PAYMENT PLAN AGREEMENT

Patient Name _____ Account Number _____

Guarantor's Name _____ S.S. Number _____

Address _____

Home Phone _____ Work Number _____

Place of Employment _____

Spouse Name _____ S.S. Number _____

Place of Employment _____

Payment Guidelines:

<u>Balance</u>	<u>Resolution Time Limit</u>
\$0 - \$300.00	Balance in full within 3 months
\$301.00 - \$500.00	Balance in full within 6 months
\$501.00 and above	Balance in full within 12 months

*** unless previous arrangements have been made ***

Down payment amount _____ ***

Balance due \$ _____ monthly / weekly

Beginning on _____

I understand these payments are to be made on a **regular** basis as stated above in order to keep my account in good standing. If payments are not made **as agreed above**, the account may be sent to a collection agency.

I _____, agree to pay the above payment plan as set forth above. If payment is received as agreed, no interest or finance charge will be incurred. It is also agreed that if payment is not received as stated above, I will pay any attorney or collection agency fees and other cost, which a court having jurisdiction, shall determine to be just and reasonable.

Signed _____

Date _____

Witness _____

Date _____

*** All payments should be sent to Algone Anchorage Interventional Pain Clinic***

9500 Independence Drive, Suite 700, Anchorage, Alaska 99507

** Please reference your account number on all payments***