ALGONE DFW
INTERVENTIONAL PAIN
5860 Collin McKinney Parkway, Suite 604,
McKinney, TX 75070
Phone: 469 -272-6142

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 Guidlines:

Balance	Resolution Time Limit
$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 DFW Interventional Pain Clinic***
5860 Collin McKinney Parkway, Suite 604, McKinney, TX 75070
** Please reference your account number on all payments***