Recurring Monthly Payment Plan Agreement Form

Patient Name: _____________________ MR #: ____________

Total Balance Due: $______________ Initial Payment: $ _______________

Remaining Balance Due: $ _________ Monthly Payment: $ ____________

First Payment Due Date: ___________ Payment Due Date: 10th ☐ 20th ☐ 15th ☐ 25th ☐

I, _____________________________ (responsible party's name) agree to make payments as set forth in this Recurring Payment Plan Agreement which are for health care services provided by Forest Health Medical Center or Forest Health Medical Center-Bucks County, whether to me or to another party for whom I am agreeing to be responsible with respect to the costs of the health care services provided. I understand that the remaining balance due stated on the date of this agreement may change as additional services are provided and/or determinations are made by my insurance plan (if insurance available). I further understand that any such changes in the remaining balance due are my responsibility, whether or not the services were provided to me or to the party for whom I am agreeing to be responsible with respect to the health care costs covered by this agreement and will be covered under this agreement unless superseded by a mutually executed Payment Plan Agreement on a subsequent date.

While the remaining balance due may change as noted above, the monthly payment amount stated in this agreement represents the *minimum* amount due on or before the Payment Due Date each month. Any Amount paid that is less than the monthly payment amount stated herein may be deemed as a failure to honor the terms of this agreement. If payment received by the provider is not honored by the responsible party's bank, a $50.00 NSF charge will be applied to the patient's account and the dishonored payment will be deemed as though no payment was received. Failure of the responsible party to make satisfactory payment per the terms of this agreement plus the NSF charge within 10 days of being notified of the dishonored payment will be deemed as a failure to honor the terms of this agreement.

I understand that Forest Health Services, LLC. is an administrative services provider that supports the Hospital in certain administrative capacities only, including, administering its billing and collections efforts. In so doing Forest Health Services is not involved in providing patient care in any respect and is not responsible for the care provided by the Hospital or its providers.

I understand and accept the terms of this agreement

As of this _______ day of ____________, 20_ _. Agreement accepted on behalf of provider by:

____ ___________________________ ________

Patient/Guarantor Signature FHS Billing Dept Signature Date

Billing Department PH# 800-282-0066

FAX NUMBER: 734.547.1401