MOUNTAIN COMPREHENSIVE HEALTH CORPORATION

P.O. Box 40
Whitesburg, KY 41858
(606) 633-4823

PAY AGREEMENT

Date:	Account Name:
Account Number:	**Guarantor Name:**
Current Address:	**Current Telephone Number:**
Current Name & Address of Employer:	**Balance Due on Account as of today's date:**

GUIDELINES FOR PAY AGREEMENT:

$ 0- $499 – 12 months
$500- $999 - 18 months
$1000-$1499- 24 months
$1500-$2500- 30 months
Over $2501- 36 months

I, ____, agree to pay Mountain Comprehensive Health Corporation **$________.00** **PER MONTH** until the above balance is paid in full. I understand that if I fail to make each payment in a timely manner, MCHC will bring or pursue any existing legal action against me to collect the full amount owed. In addition to the remaining balance on my account, I understand I will also be responsible for all costs and attorney fees incurred against myself in pursuing the legal action and/or collection efforts against me. I understand that my account must be kept current, with all future balances, including co pays and deductibles, being paid at time of service.

My first payment will be made on the ________ day of ______________, 20_____, and the payment will be under the above guidelines, unless expressly approved by Administration.

Signed this ____________ day of ____________, 20_____.

____ ____

Signature **Witness**

Revised 4.24.12