ATCHISON HOSPITAL

800 Raven Hill Drive Atchison, KS 66002 (913) 367-2131 (913) 674-2023 FAX atchisonhospital.org

Atchison Hospital Payment Plan Agreement

Patient Last Name: _____ First Name: _____
Guarantor Last Name: _____ First Name: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Account #:_____ Date of Service: _____ Balance: _____
Account #:_____ Date of Service: _____ Balance: _____
Account #:_____ Date of Service: _____ Balance: _____
Account #:_____ Date of Service: _____ Balance: _____

Patient/Guarantor agrees to pay the Atchison Hospital each month, in the amount of $_____ until this/these accounts are paid in full. I understand that if one monthly payment is missed the amount due for the next month is two monthly payment amounts.

Signature of Patient/Guarantor: _____ Date: ___/___/____

Financial Counselor (or Designee): _____Date: ___/___/____

Cc: Guarantor and Patient Account Files

Patient/Guarantor understands and agrees that if none of the above provisions are met, the entire amount of the Total Billed Charges will become due and payable.

Patient/Guarantor further understands that Atchison Hospital shall use its customary collection procedures and policies to attempt to recover the full amount of the Total Billed Charges.