McKenzie Health Payment Agreement

Patient Name (printed): _____ Guarantor Number: _____

Current Mailing Address: _____

Current Phone Number: _____ *Payment Start Date (After initial payment):_____

Credit/Debit Card Number: _____ Exp: _____ CVV: _____

Estimated Account Balance Range	Maximum Months to Pay	Estimated Payment Per Month
$100 - $200	3 Months	
$201 - $500	6 Months	
$501 - $800	9 Months	
$801 - $1,200	12 Months	
$1,201 - $2,500	15 Months	
$2,501 - $5,000	18 Months	
$5,001 - and above	24 Months	

I understand that a McKenzie Health Financial Counselor will review all outstanding account balances prior to setting the payment arrangement to establish the maximum amount payable by the patient/guarantor. The payment agreement may be reviewed every 90 (ninety) days for the possibility of a payment in full, settlement in full, and/or increase in the monthly payment amount.

In review, I understand that defaulting on payment will result in a review of all future visits and may result in my account being sent to a collection agency. Payments are due no later than the agreed payment date.

My signature indicates that I have read and agree to the terms and conditions of my payment plan, and I hereby authorize payments to McKenzie Health using the credit card number provided on the agreed upon dates.

If I do not receive a payment reminder within 30 days from the date of this contract, then I should contact McKenzie Health at **(701) 444-8798**.

Guarantor/Patient Signature: _____ Date: _____

***Statements will be mailed after 1st initial payment.**

McKenzie Health | www.mckenziehealth.com
Address: 709 4th Ave. NE, Watford City, ND 58854
Phone: 701-842-3000 | Fax: 701-842-6248