Payment Agreement for APIA Health Services

I agree to pay for the services rendered by **Aleutian Pribilof Islands Association**, as indicated below. Aleutian Pribilof Islands Association, Inc. is confined to deduct only the monthly amount agreed to below, unless otherwise informed by notification from the patient.

Date: _____

Patient Name: _____DOB: _____

Address: _____Phone: _____

Amount Due: _____ as of date: _____

Payment schedule as follows:

☐ Payments will be made by cash or check

☐ Payments will be made by credit card, which I authorize you to use

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On the _____ day of each month, the following payment in the amount of $_____ will be processed for the duration of _____ months (not to exceed 24 months) until the balance is $0.00.

Credit Card:
Number _____ Exp_____ 3-dig Code_____

Name as appears on card_____

It is understood that if the patient misses payments, without prior notification and agreement, APIA reserves the right to transfer collections to a collection agency after 3 months of non-payment.

Date:_____

_____
Signature of Patient or Guarantor

APIA STAFF NOTES

Information of Guarantor if different from Patient:

Name:_____

Address:_____

Phone:_____