GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Payment Plan Agreement

I have reviewed Greater Seacoast Community Health's Financial Policy and understand the policy, including but not limited to the items listed below.

- I have been given a Sliding Fee Application and have reviewed it.
- If I do not wish to apply for the Sliding Fee Scale Program or do not qualify for the program based on my income, I will be responsible for the full fee.

Due to financial constraints, I wish to apply for a Payment Plan to extend my payment terms. In signing this Payment Plan Agreement, I understand the following:

- I have been informed and understand my balance.
- I will be on this payment arrangement until my balance is paid in full.
- Due to the constraints of Greater Seacoast Community Health's billing system, payment plans cannot be established for a certain part of a balance. The system only allows a payment plan for the total amount owed.
- For all future visits, I am required to pay my insurance co-payment or, if applicable, my visit deposit amount at the time of each visit, in addition to my monthly payment plan amount.
- A monthly statement will be issued each month and payment will be due within 30 days until my balance is paid in full.
- I will notify the Billing Department of any change in address.
- If I miss two consecutive payment plan payments my account will be sent to an outside collection agency for assistance in receiving payment. This payment plan will also be void at that time.
- If I am not able to make my payment when due, I will contact the Billing Department at (603) 841-2340 or (603) 812-0834 immediately, before my next payment is due.

By signing below I agree to the terms set forth in this agreement.

_____ _____

Print Patient/Guarantor Name | Date of Birth

_____ _____

Patient/Guarantor Signature | Date

_____ _____ _____

Account Balance (as of below date) | Monthly Payment | Plan Start Month

_____ _____

Witness | Date