GILLETTE INTERNAL MEDICINE ASSOCIATES, PC
407 S. MEDICAL ARTS COURT, SUITE D
GILLETTE, WYOMING 82716

FINANCIAL CONTRACT

I, ____,

on behalf of: ____,
agree and promise to pay monthly payments to Family Health for medical services rendered until my bill is paid in full.

____ (init) I understand that if I do not comply with this agreement and payment schedule, the full amount of the balance will immediately become due and payable and may result in my account being turned to a collection agency.
____ (init) I understand that if I do not comply with this agreement and payment schedule, that I may lose my privilege to be a patient of the clinic.

____ (init) I understand that there will not be a finance charge or interest imposed under this agreement as long as the agreement is met in full.

____ (init) I understand that my payment agreement is due and payable as follows:

Initial Payment: $____________ Date__________ _____ (init)

Monthly Payments: $____________ Day __________ _____ (init)

SUMMARY: I understand that I am agreeing to a regular monthly payment and that failure to maintain payments will prevent my privilege to continue to be seen in the clinic.

Signature ____ Date _________
of Responsible Party

Witness ____ Date _________