
**416 Durant Street**
**South Hill, VA 23970**
**434-774-2581**

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## Payment Agreement

**I, _____agree to pay $ _____by the 1st of each month.**

**I also agree that if payments are not made in the full amount stated above and/or payments are not received on time, the entire balance will be considered delinquent and will be due immediately or could be turned over to a collection agency. The payment agreement must be for 10% of the total amount due or $25.00, whichever is greater.**

| _____ | _____ | _____ |
|---|---|---|
| **Print Patient Name** | **Social Security Number** | **Date of Birth** |

| _____ | _____ |
|---|---|
| **Patient/ Responsible Signature** | **Date** |

| _____ | _____ |
|---|---|
| **Practice/ Physician Representative** | **Date** |