PRIORITY HEALTH CARE©
A UNIVERSAL APPROACH TO CARE

REQUEST FOR PAYMENT PLAN

If you are experiencing financial hardship, please fill out the following application. Our staff will review it and contact you. You must submit supporting documentation with your request.

Section 1 – Demographics

Patient Name

Mailing Address | **City** | **State** | **Zip Code**

Phone | **Email**

Section 2 – Agreement

For services received, the undersigned, _____ *(Print patient/guarantor name),* hereby agree to pay to the order of Priority Health Care (PHC), the sum of $ _____ as indicated below.

Section 3 – Payment Schedule

Installment	Payment Due Date	Amount
Month 1	1/1 – 1/31	$
Month 2	2/1 – 2/28	$
Month 3	3/1 – 3/31	$
Month 4	4/1 – 4/30	$
Month 5	5/1 – 5/31	$
Month 6	6/1 – 6/30	$
Month 7	7/1 – 7/31	$
Month 8	8/1 – 8/31	$
Month 9	9/1 – 9/30	$
Month 10	10/1 – 10/31	$
Month 11	11/1 – 11/30	$
Month 12	12/1 – 12/31	$
Total		**$**

Section 4 – Patient Acknowledgements

I declare, under penalty of perjury, that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

I hereby acknowledge that I am applying for assistance under a U.S. HRSA funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

Signature of this document denotes that all parties agree to the terms of this arrangement.

Patient, Parent or Guardian Signature **Date**

Patient Name (Please Print)

OFFICE USE ONLY

Payment Plan	☐ **Approved**	☐ **Denied**

Date of Service	Amount
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total	**$**

Application Received By (Staff Full Name) **Date**

Senior Staff Accountant / Revenue Cycle Manager **Date**

Patient Notification

Method	Date	Staff Name
☐Verbal ☐Patient Portal ☐Mail		

Revenue Cycle Notification

Method	Date	Staff Name
☐Email		

Revenue Cycle Staff	
Date Posted in Practice Management System	
Total Amount Posted in Practice Management System	$
Signature	