RENAL ASSOCIATES
of West Michigan, P.C.

330 East Beltline Ave NE Suite 100
Grand Rapids, Michigan 49506-1267
Phone (616) 752-6235 Fax (616) 752-6324
Toll Free 1-888-752-RAWM (7296)

Credit Card

PATIENT PAYMENT AGREEMENT

PATIENT'S NAME _____ DOB _____

PATIENT'S ADDRESS _____

_____PHONE #_____

Effective _____, I understand that I have an outstanding balance with
(DATE)
RENAL ASSOCIATES OF WEST MICHIGAN, P.C. $_____.

This is the remaining balance for dates of service on or before this date which insurance has paid or which is not covered by insurance. Any balance due from charges yet to be paid by insurance will be added to this balance. I understand that this balance is my responsibility and may change if I incur future charges for service rendered after this date.

I agree to make ☐ (monthly) ☐ (bi-weekly) ☐ (weekly) payments of $ _____

until this balance is paid in full, beginning on _____(Your payments will begin on this day).
(DATE)

We accept the following credit cards for payments involving payment plans. An automatic deduction will be taken from your card every month to insure the payment has been made. If your card declines for whatever reason, you will still be responsible for the balance. We will continue to try to make contact with you over the phone, but if we cannot reach you, this payment plan will be marked void after two months of non-payment. It is your obligation as the patient to notify us of any changes to your credit card information provided below.

With signing this payment agreement, you are responsible for the current balance in addition to any new charges your account may incur. Every month, you will be receiving a letter with an update on your current balance.

Card Number: _____ VISA ☐ MasterCard ☐

Expiration Date: ---------/---------- Month/Year

3 or 4 digit Security Code _____

DISCOVER ☐ AMERICAN EXPRESS Cards ☐

I hereby authorize a monthly deduction from my provided credit/debit card information. I further understand this is a binding contract for payment of my outstanding bill. If I fail to make the agreed payment, I may be responsible for any and all attorney and court fees required to collect this account by ***RENAL ASSOCIATES OF WEST MICHIGAN, P.C.***

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) DATE

_____ _____
RAWM STAFF ACKNOWLEDGEMENT DATE

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Check

PATIENT PAYMENT AGREEMENT

PATIENT'S NAME _____ DOB _____

PATIENT'S ADDRESS _____

_____PHONE #_____

Effective _____, I understand that I have an outstanding balance with
(DATE)

RENAL ASSOCIATES OF WEST MICHIGAN, P.C. $_____.

This is the remaining balance for dates of service on or before this date which insurance has paid or which is not covered by insurance. Any balance due from charges yet to be paid by insurance will be added to this balance. I understand that this balance is my responsibility and may change if I incur future charges for service rendered after this date.

We ask that you continually submit a check every month to our practice. If your check bounces for whatever reason, you will still be responsible for the balance, as well as a $35 fee for the bounced check. If this occurs, we will ask you to provide a debit/credit card or a money order. It is your obligation as the patient to notify us of any changes to your information provided below.

I agree to make ☐ (monthly) ☐ (bi-weekly) ☐ (weekly) payments of $ _____

until this balance is paid in full, beginning on _____ .
(DATE)

With signing this payment agreement, you are responsible for the current balance in addition to any new charges your account may incur. Every month, you will be receiving a letter with an update on your current balance. If we have not received payment in two months while trying to attempt to call you, this payment plan will be void.

I hereby authorize a monthly payment to be posted to my account. I further understand this is a binding contract for payment of my outstanding bill. If I fail to make the agreed payment, I may be responsible for any and all attorney and court fees required to collect this account by ***RENAL ASSOCIATES OF WEST MICHIGAN, P.C.***

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) DATE

_____ _____
RAWM STAFF ACKNOWLEDGEMENT DATE