Intensive Health
a stepworks company

Patient Payment Agreement

Name: _____

Date of Birth: _____ / _____ / _____

Balance Due: $ _____

Payment is typically due at the time of service. In special circumstances, patients may enter the following agreement:

Beginning on this date: _____ / _____ / _____

I agree to pay $ _____* per ☐ month ☐ week

until…

☐ my account balance is clear

or

☐ other (describe): _____

*This amount is in addition to the co-pay amount due at the time of visit.

Account Number: _____

Balance Due: $ _____

Responsible Party Signature: _____

Staff Initials: _____

Date: _____ / _____ / _____