

1806 Charlton Court Goshen, IN 46526 574-534-6752

## **Financial Agreement**

Person Responsible:		Acct #:	
Family Members:			
Address:			
City:	_ State:	Zip:	
Phone:	_		
Balance Due: \$	-		
I agree to pay \$ monthly fo	r	months.	
1 <sup>st</sup> payment due:			
the account should be delinquent for a p Medicine, I hereby acknowledge that my	period of to y account	I agree to keep this agreement, in thirty (30) days, without notification to Kr will be sent to collections and I will be ter all the balance, collection fees (up to 50%)	abill Family rminated
I certify that I have read and understand	this agre	ement.	
Responsible Party		Date	
Witness		 Date	