2240 Karisa Drive, Suite 2
Goshen, IN 46526
574-534-6752

**Financial Agreement**

Person Responsible:_____ Acct #:_____

Family Members:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

Balance Due: $_____

I agree to pay $_____ weekly / bi-weekly / monthly for _____ months.

1st payment due: _____

Payment due by the _____ of each _____. I agree to keep this agreement, in the event the account should be delinquent for a period of thirty (30) days, without notification to Krabill Family Medicine, I hereby acknowledge that I will be responsible for all the balance, collection fees (up to 50%), court costs and/or attorney fees.

I certify that I have read and understand this agreement.

_____ _____
Responsible Party Date

_____ _____
Witness Date