(Specialty Practice Letterhead)

Repayment Agreement

Patient Name:_______________________

Parent 1 Name if Minor Child : ____________________

Parent 2 Name if Minor Child :_____________________

I (we) agree to the repayment plan outlined on this document for services provided under contract. I do understand that should a collection agency need to be employed after the account becomes past due, additional charges may be assessed to the balance , including fees and interest . I also agree to pay attorney fees and costs to release information needed to collect on the past due bill.

Contracted amount for services: $___________

Amount due today upon signing contract $__________

Additional payments will be made as such:

Monthly due by___________(day of the month) each payment $__________

Other:____

____

___________________________________ Date__________________________

Patient (Over 18 years of Age)

OR

___________________________________ Date__________________________

Parent 1

___________________________________ Date__________________________

Parent 2

___________________________________ Date__________________________

Provider of Service Representative

Medical **Asset Recoveries**
3300 County Road 10, Suite 100
Brooklyn Center, MN 55429-3064

Phone: **(763) 585-2800**, ext. 7109
Toll-free: **(866) 585-2800**, ext. 7109
Website: **www.ORICollect.com/MedicalAssetRecoveries.html**