Pay Agreement

Date: ___________________________

Patient Name: ____

Account: ____

Balance: ____________________________________

I, ____, agree to pay Ancor Health Center, PA for medical and surgical services provided to me or the patient that I am responsible for on all dates of service prior to today. I also agree to pay any future balances tat I may incur.

I agree to pay $ _______________________ and any other balance that may have incurred during this time. I agree to pay the amount of $__________________ on the ___________________ of each month, until the amount has been paid in full.

I understand I may increase the amount of my monthly payments and may pre-pay the balance at any time. Please note, if for any reason you are unable to make your payments, please call the Billing Office at 903-236-8600. We will be happy to assist you.

Signature Patient/Guardian: ____

Ancor Employee Signature: ____