PAYMENT AGREEMENT

Today's Date: ___________________________

Co-pays are due and collected at the time of service.

Deductibles and Coinsurance are determined after insurance has processed. However, if you have a large deductible we require that you pay $100 towards your deductible at the time of service.

For remaining deductibles and coinsurance:

I agree to have Emurgent Care LLC or it's authorized payment agent to charge my ACH/Credit/Debit for today's service NOT TO EXCEED the amount of $200.00 for any expenses for my services today that are not covered by my insurance and/or legally owed by me. If I have insurance, this transaction will occur once my insurance has been processed.

In addition if I provide a valid email address, I will receive an email reminder 3 days before any authorized charges/debits would be processed. If the amount owed is greater than I have funds for, I can call the billing department at 503-383-9107 and request an automatic payment plan that fits my budget.

I understand that this may not cover the full expenses that I may be responsible for and that any amount over the authorized amount will be billed electronically to the email address that I have given.

In the event that the amount that I paid today is more than what my insurance requires, Emurgent Care will refund my credit to my ACH/Credit/Debit account.

This authorization will remain in effect until I provide written notice of cancellation to the clinic. Authorization for services already rendered cannot be canceled or refunded. I agree to notify the clinic in writing of any changes in my payment or other information.

____ ____
Name as it appears on Card/ACH Account Email Address

____
Billing Address City State Zip Code

____
Phone Number

Authorized Signature: ____ Date: ___________________