SIERRA VISTA HOSPITAL

OFFICE USE ONLY:

(Installments over 12 mo. Approval)

BOM Initial:_____

Date Approved:_____

Payment Plan

(This disclosure is in compliance with the Truth in Lending Act).

ATHENA MR# : _____

Patient Name _____ **CERNER MR#:** _____

Responsible Party (Guarantor) _____

C Encounter #	Balance Due	Claim #	Balance Due	A Claim #	Balance Due
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
	$ -		$ -		$ -
Sub-Total	$ -	**Sub-Total**	$ -	**Sub-Total**	$ -

Total Balance	**$ -**
Less Deposit	
Total Balance Due	**$ -**

The amount financed is payable to Sierra Vista Hospital/Community Healthcare in installments of _____ The **first installment is due** in _____ and all subsequent installments are due on the same day of each month until paid in full.

If the payments are not received as stipulated and no other arrangements have been made, this agreement shall be consided to be in breach and the entire balance will be due and payable on demand.

If full payment is not received within 30 days of the breach, the account will be turned over to a collection agency and the responsible party will have to deal directly with the collection agency.

If you accumulate other outstanding balances that are not on this payment plan but you would like them to be added, you must notify financial counselor to make payment arrangments to do so. ***(Please note that you may be asked to increase your payment amounts when additional accounts are added)***

I hereby understand the above stipulations.

Signed: _____ Date: _____

Mailing Address: _____

_____

PHONE: _____

NOTES: □ _____

_____

Mail all Payments to: Sierra Vista Hospital
PO Box 561638
Denver, CO 80256

Sign up and Pay on the Portal
www.svhnm.org

Or Call: 575-824-7312- *SVH Bill Pay Department* OR 575-743-1240- *Financial Counselor*