



PONDERA MEDICAL CENTER

(406) 271-3211 805 Sunset Blvd. PO Box 758 Conrad MT 59425-0758 www.ourpmc.com

MONTHLY PAYMENT AGREEMENT

I, _____ agree to make monthly payments to Pondera Medical Center on each of the following accounts as outlined below until the balance is paid in full.

Account Number	Patient Name	Balance Due	Monthly Payment Amount
Example. 012345	John Doe	\$438.91	\$45.00

I certify the above monthly payment amount(s) are acceptable to Pondera Medical Center according to the following Credit Policy. If the amount is not within Pondera Medical Centers guidelines PMC reserves the right to refuse acceptance of this agreement.

CREDIT POLICY	
Account Balance	Required Monthly Payment
\$0 - \$50	Full Amount
\$51 - \$100	\$25.00
\$101 - \$200	\$30.00
\$201 - \$300	\$35.00
\$301 - \$400	\$40.00
\$401 - \$500	\$45.00
\$501 - \$600	\$50.00
\$601 - \$700	\$55.00
\$701 - \$800	\$60.00
\$801 - \$900	\$65.00
\$901 - \$1000	\$70.00
\$1001 and up	8% of balance due

Failure to remit one monthly payment will result in having the account(s) referred to a collection agency.

Signature

Date

Signature

Date

Accepted by

Date

RETURN TO:

By Mail:
Pondera Medical Center
PO Box 758
Conrad MT 59425

By Fax:
(406) 271-7661