



Colorado Springs Family Practice

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DATE: _____

ACCOUNT# _____

NAME: _____

BUDGET BILLING AGREEMENT:

I agree to make three consecutive installment payments to Colorado Springs Family Practice, for my balance of \$ _____ beginning on _____, monthly/every two weeks, for the amount of \$ _____.

I also agree that if I do not call the billing office because I cannot make a payment, a double payment will have to be made. I agree to keep the billing office informed of any changes that would require other arrangements to be made on my account.

This agreement is only for this date of service. I understand that future visits will be paid in full at time of service.

I understand if I do not commit to these terms, my account will be turned over to an outside agency for collection, and I will lose the care of the Physicians at Colorado Springs Family Practice.

SIGNATURE: _____ DATE: _____

Our office is willing to work with you in any way we can, as long as we are kept informed. If there is lack of communication, that is where the problems begin, and it leaves us no choice but to turn the account over to an outside agency.

Thank You,

Collection Department
Colorado Springs Family Practice

2960 N. Circle Dr. Suite 200
Colorado Springs, CO 80909
(719)634-8891