



39 Norman Street, Salem, MA 01970 USA

PAYMENT PLAN AGREEMENT

In general, it is required that diagnostic services rendered by Commonwealth Diagnostics International, Inc. (“CDI”) be paid for in full. Therefore, once your insurance company has determined the amount of coverage it will allow for CDI’s diagnostic services, any co-payments, co-insurance, or deductible amounts are your responsibility (“Patient Responsibility”).

By signing this agreement, Patient agrees to pay for the Patient Responsibility in accordance with this plan. The Patient Responsibility as of _____ is \$_____ for the following:

Date(s) of Service Rendered: _____

This Patient Responsibility amount is to be paid for in the following manner¹:

\$_____ will be paid today; and

\$_____ will be paid each month for the next two (2) months.

<u>Patient Information</u>	<u>Billing Information</u>
Name:	Name on Card:
Address: City, State, Zip:	Credit Card Number:
Phone:	Expiration Date:
Email:	Zip Code for Card:

This agreement may be renegotiated in the future with the consent of both parties and may be replaced only by an agreement signed by both parties.

Patient Acknowledgment

Signature: _____

Name: _____

¹ As a condition of agreeing to this payment plan, CDI requires a deposit amount be paid today and will not extend payment plans beyond three (3) months. CDI will charge the provided credit card in accordance with the above payment schedule.