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 manner[1]:

$_________ will be paid today; and

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

Patient Information	Billing Information
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.