St. Clair County Community Mental Health

Outpatient Installment Payment Agreement

Individual: ____ Case #: _________ Date: _____________

Responsible Party: ____ Outstanding Balance: $_________________

To assist you, SCCCMH is offering this payment plan with no finance or interest charges. If SCCCMH receives the installment payments set forth in this agreement, we will not pursue any additional collection actions on your account.

However, if you choose not to make installment payments on the terms of this agreement, you will owe the entire outstanding balance immediately. Non-payment will result in this account being sent to collections, which could have a negative impact on your credit.

If you have insurance coverage, SCCCMH will submit all claims to your insurance for reimbursement. **You will be responsible for any copays, deductible or coinsurance.**

Below is the payment plan to pay off your past due balance for the services you have already received. You are expected to:

1. Make the payments as agreed upon.
2. Make payments until the past due balance is zero dollars ($0.00).

Total past due balance is $____________________ as of ________________.

I agree to pay $_____________________ (25% of outstanding balance) on ______________ to accept this Installment Payment Agreement.

I agree to pay $_____________________ (25% of outstanding balance) per month over the next three (3) months by the dates listed below.

Date: _____________ Date: _____________ Date: _____________

In addition to this Installment Payment Agreement, payments for any current services *(if applicable),* will also be made monthly according to the current invoice due dates.

If no payments are received within 60 days of your last payment, your unpaid balance will be turned over to a collection agency and you will not be able to schedule future appointments.

Sign below to agree to the terms listed above.

___________________________________ ___________________________________ __________________

Individual/Responsible Party Signature Print Name Date

___________________________________ ___________________________________ __________________

SCCCMH/Preparer Signature Print Name Date

Clinical Form: #03-0004
Revised Date: 5/1/2024
Policy Ref: #07-003-0025, #07-003-0080
EHR: Administrative/Financial, Fee Determination/Payment Agreements, Installment Payment Agreement