



1320 22nd Ave
Fairbanks, AK 99701
(P) 907-452-4777
(F) 907-452-4787

Promise of Payment Agreement

Date: _____ Patients Name: _____

I am unable to pay my current balance of _____ for my facility fees and agree to the following terms:

\$_____ per month, each month, by the _____ of each month, beginning _____.

If I am unable to make my scheduled monthly payment, I understand that I must call billing (at 1-877-770-9601 then press 0) **prior** to my payment due date.

If I fail to make my scheduled payment, I understand that my account will be reviewed for possible referral to collections. I further understand that I will be responsible for any and all collection/legal fees associated with my debt to *Fairbanks Community Imaging LLC*.

I understand and agree to the above terms.

Signature of Patient, Guardian, or Legal Representative

Date