



COLORADO MOUNTAIN MEDICAL, P.C.
PO BOX 5850
EAGLE, CO 81631
970 926-6350

PAYMENT PLAN

Thank you for inquiring about our payment plan. We do not want a financial obligation to interfere with your medical care; therefore, we have set up the following plan to assist you.

- CMM will accept monthly payments of \$100.00 if your balance is under \$800.00.
- If your balance is over \$800.00, CMM will accept monthly payments of the balance divided by 8

Patient's Name : _____

Account #: _____

Balance Due: _____

Immediate Family members covered under this payment plan:

I agree to make a payment of _____ to Colorado Mountain Medical, P.C. on the 1st or 15th (circle one) of each month until the balance noted above is paid in full.

Signature _____ Date _____

Complete for credit card payments:

Card Holders Name _____

CC# _____ Exp. Date _____

Many patients find it easier to have CMM automatically debit the charge card listed above each month until balance is paid. Would you like this service? YES NO (circle one)

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