PHYSICIAN NETWORK SERVICES

# Payment Agreement

Name of patient: _____ Account Number: _____

Date(s) of service: _____ Clinic: _____

Total amount due:_____(itemized bill attached)

1. For value received, I/we promise to pay to Physician Network Services, the total amount stated above. I/we will make a down payment of $_____ on _____. If we do not receive your payment by the above date, the balance in full, is due immediately. After this down payment, I/we will send one payment of $_____per month on/or before 10th, 20th or 30th (choose one)of each month until the total outstanding balance of $_____ is paid in full. Any missed payments will result in this agreement being null and void. I/we will make each payment to:

   Physician Network Services
   Central Business Operations
   (806) 761-0334

   Mailing address:
   5219 City Bank Parkway, Suite #35
   Lubbock TX 79407

   Physical Address:
   3602 Slide Rd Ste B27
   Lubbock, TX 79414

2. There will be no interest charged on this amount. This payment agreement is not secured. Credit life insurance, credit disability insurance, health and accident, and property insurance are not required to enter into this payment agreement.

3. I/we can pay the full balance at any time without penalty.

4. If this account is not paid when due, Physician Network Services shall be entitled to collect all reasonable costs and expenses of collection, including, but not limited to reasonable attorney's fees, whether or not suit is brought to collect this agreement.

5. I/we waive presentment for payment, notice of dishonor, demand, and protest.

Printed name: _____

Address: _____

Date: _____

Signature: _____