Johnson Memorial Health Services
1282 Walnut Street
Dawson, MN
320-769-4393

Payment Arrangement Request From

Date(s) of Service_____

Account Number(s)_____

Patient(s)_____

Social Security Number_____

Guarantor_____

Address_____ City_____

State_____ Zip code _____ Phone Number_____

Employer_____

Address_____City_____State_____

Zip code _____ Phone Number_____

As of _____ your amount due is $_____. In the event full payment can not be made, I agree to make payments as stated below.

I agree to pay _____per _____until the above accounts are settled in full.

Should I fail to make a payment within 30 days as agreed upon, I understand that my account could be forwarded to a collection agency or sent to Revenue Recapture for further action.

Signature_____

Witness_____ Date _____