Alpine Foot & Ankle Clinic
FOOT & ANKLE CARE FOR THE WHOLE FAMILY

PAYMENT AGREEMENT CONTRACT

THIS CONTRACT MUST BE RETURNED BY:

_____ WITH YOUR NEXT PAYMENT.

PATIENT NAME:_____

RESPONSIBLE PARTY (if applicable):_____

ACCOUNT NUMBER:_____

DATE OF SERVICE:_____

ADDRESS:_____

PHONE NUMBER:_____

I _____ (responsible party) agree to pay Alpine Foot and Ankle Clinic $_____ per month until my balance is paid in full. I understand that in the event I incur other charges in the future causing my balance to increase, this monthly payment may be adjusted, and a new contract will need to be completed. **If I am having financial difficulty and cannot make my monthly payment, I agree to notify Alpine Foot and Ankle Clinic as soon as possible.** If my account is 30 days delinquent, it will be sent to Collections.

Signature:_____ Date:_____

Alpine Foot and Ankle Clinic Authorized
Signature:_____ Date:_____

****Please return to our office via mail or fax (406)549-9807****

Dr. G. Gregg Neibauer, DPM
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