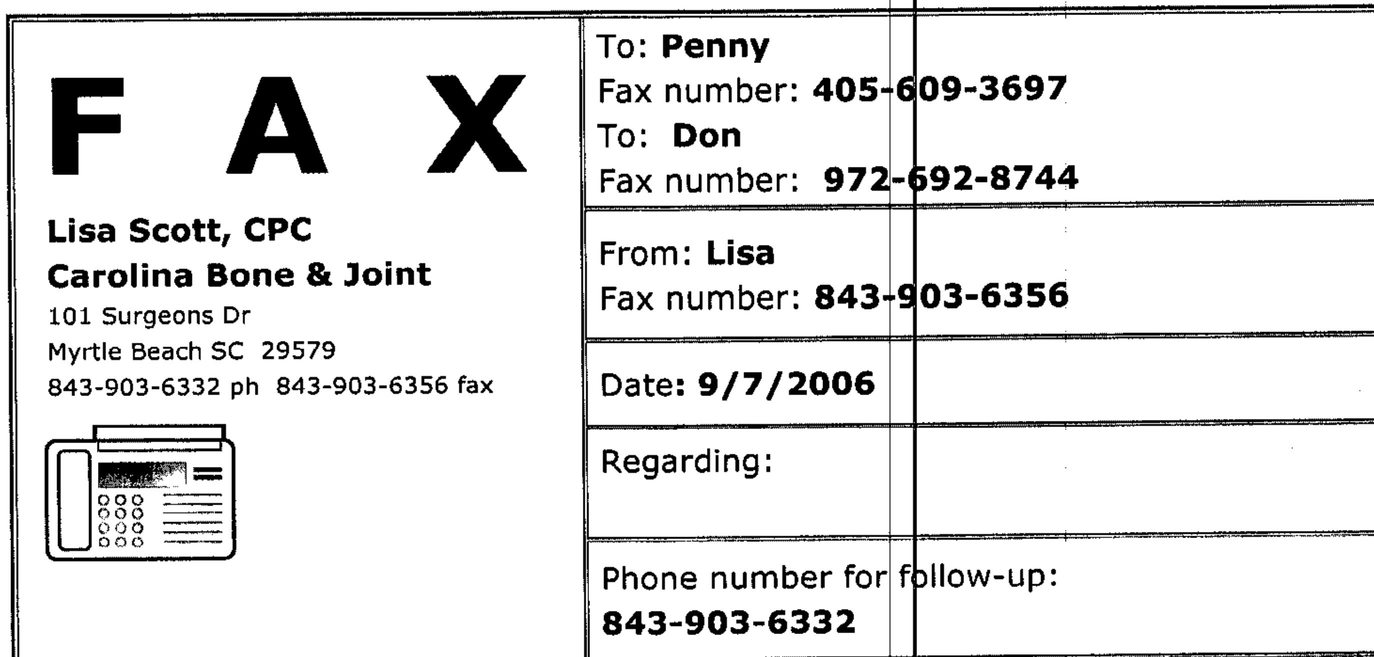

FAX

Lisa Scott, CPC
Carolina Bone & Joint
101 Surgeons Dr
Myrtle Beach SC 29579
843-903-6332 ph 843-903-6356 fax

To: **Penny**
Fax number: **405-609-3697**
To: **Don**
Fax number: **972-692-8744**

From: **Lisa**
Fax number: **843-903-6356**

Date: **9/7/2006**

Regarding:

Phone number for follow-up:
843-903-6332

Penny + Don - here are the forms you requested. Feel free to edit them as your practice needs.

Lisa :)

this form generates from my practice mgmt software and auto populates pt name, address + account info

Carolina Bone and Joint Surgery Center
101 SURGEONS DRIVE
MYRTLE BEACH, SC 29579

09/07/06

Pt Name
Address

Acct #
Balance Due

R

Dear

Per our recent conversation, we have set up a payment plan for your account. You will be making payments of $ per month. These payments will start . In order to keep your account current, please remit future payments within two weeks of receiving your monthly statement.

I realize that these are difficult economic times, and finances might be tight. We don't want this to be a burden for you, so if you have any problems, ie unable to pay one month, need to adjust your payment amount, etc., please feel free to call me at 843-903-6332.

If you agree to the aforementioned payment plan, please sign and date the bottom of this letter and return it to the facility with your first payment. Thank you.

Sincerely,

Lisa Scott, CPC
Coding and Reimbursement Specialist

****

I agree with the above-mentioned payment plan established for my account with with Carolina Bone & Joint Surgery Center. I will call CBJSC to inform them if I will be unable to make my payment as arranged.

Pt Name
Balance
Acct #

Patient/Guarantor Signature

Date

PROMISSARY NOTE

I, ____________________, as responsible party (Guarantor) for patient ________________, promise to pay ____________________ for the use of their facility.

My estimated financial responsibility is $_______, including services rendered on _______. Following my downpayment of $_____, payments in the amount of $______ will be made on a monthly basis with all payments being due in our billing office on the 5th of each month, beginning September 5th, 2006.

It is fully understood that the above financial responsibility is only an estimate based on the procedures scheduled. If additional procedures are performed, this amount will increase. If payment is not made as agreed in the above terms, any remaining balance will be referred for legal action immediately. It is further agreed that in the event of any and every change in address and/or employment status, the guarantor will notify ________________immediately.

____

Signature of Patient or Guarantor

Patient's Name   Guarantor's Name (if different)

Street Address   City, State, Zip Code

County of Horry
State of South Carolina

Subscribed and sworn to before me, in my presence, this 25th day of August, 2006 by Lisa Scott, CPC, Notary Public.

My commission expires 9/11/2013.

this form is printed on letterhead and notarized