



# River Hospital *Serving the Thousand Islands Region*

4 Fuller Street • Alexandria Bay • New York • 13607

315-482-2511 telephone

315-482-4981 facsimile

Date: \_\_\_\_\_

Guarantor: \_\_\_\_\_

### Payment Agreement

You have agreed to make payment arrangements for your outstanding balance due to River Hospital, Inc. Please review and verify the following arrangements we have discussed. If there is any discrepancy or you find you are unable to make your payments, please contact us immediately at (315) 482-1230. Please make checks payable to River Hospital, Inc.

Your total outstanding balance due is \$ \_\_\_\_\_.

This balance consists of the following accounts:

Name: _____	Acct # _____	\$ _____
Name: _____	Acct # _____	\$ _____
Name: _____	Acct # _____	\$ _____
Name: _____	Acct # _____	\$ _____

\*Please note second page of accounts if there are more than listed on this page.

You agreed to pay \$ \_\_\_\_\_ per week/bi-week/month starting on \_\_\_\_\_ until your debt is resolved with River Hospital, Inc.

Your new contract account # \_\_\_\_\_ should be used on all payments and correspondence.

Attached is a contract you must sign and send back for our records. Please keep this copy for your records. Please send your first payment as agreed along with the contract back to:

River Hospital, Inc  
4 Fuller Street  
Alexandria Bay, N.Y. 13607

Thank you,  
Cherie B.  
Credit and Collections Clerk  
(315) 482-1230

American College of Radiography Accredited Mammography Imaging Facility.





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## River Hospital, Inc. Payment Contract Account # \_\_\_\_\_

The outstanding balance due to River Hospital, Inc. is \$ \_\_\_\_\_.

This balance consists of the following accounts:

Name: \_\_\_\_\_ Acct#: \_\_\_\_\_ \$ \_\_\_\_\_

Name: \_\_\_\_\_ Acct# \_\_\_\_\_ \$ \_\_\_\_\_

Name: \_\_\_\_\_ Acct# \_\_\_\_\_ \$ \_\_\_\_\_

Name: \_\_\_\_\_ Acct# \_\_\_\_\_ \$ \_\_\_\_\_

\*Please note second page of accounts if there are more than listed on this page.

I \_\_\_\_\_ agree to pay \$ \_\_\_\_\_ to River Hospital, Inc. on a \_\_\_\_\_ basis until my balance is paid in full. I agree to contact River Hospital, Inc prior to my due date if I am unable to fulfill my obligation barring any unforeseen circumstances. I understand that if I do not honor this contract as stated my outstanding balance will be sent to a collection agency. The contract is effective \_\_\_\_\_. The due date for my payments is expected on the \_\_\_\_\_ of every \_\_\_\_\_.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of responsible party

Please send this page of the agreement back signed and dated along with the agreed upon payment amount.

Thank you for your cooperation with this matter.

Cherie B.  
Credit and Collections Clerk  
(315)482-1230

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- Second page of accounts as needed for contract # \_\_\_\_\_

Name: _____	Acct#: _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct#: _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct#: _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct#: _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____
Name: _____	Acct# _____	\$ _____

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