

Twin Forks Clinic, Inc

P. O. Box 363
Wray, CO 80758
970-332-3116

P.O. Box 449
Benkelman, NE 69021
308-423-2895

Dr. Michael Downey

Dr. Rodney Auffet

Dr. Justin Gdanitz

Payment agreement:

Name _____ Spouse _____

Address _____

Place of employment _____ Spouse _____

Work phone number _____ Spouse _____

Home phone number: _____

Social Security number: _____

Drivers License number: _____

I, _____, will pay Twin Forks Clinic, Inc. for services performed. I understand a late charge is applied to all accounts after 30 days. I also understand the rate is 1.5% per month which is the annual percentage rate of 18%. The minimum finance charge is \$3.00 a month. ***I understand that if this account is delinquent and goes to court I am responsible for any court cost occurred.*** We accept cash, checks, visa, and master card for payment. We can accept a check now for your payment and hold until _____.

I will have the balance paid by _____ (Date) _____ (Amount)

If payment cannot be made in full arrangements for payments will be as follows:

Payment plan: 1st payment _____ (Date) _____ (Amount)

2nd payment _____ (Date) _____ (Amount)

3rd payment _____ (Date) _____ (Amount)

Signature _____ Date _____