GOVE COUNTY MEDICAL CENTER
PO BOX 129
QUINTER, KS 67752

Payment Plan Agreement

Patient Name: _____ Patient Account Number: _____

Patient Account Balance: _____

Thank you for choosing Gove County Medical Center (GCMC) as your healthcare provider.

Per the financial policy, patients and guarantors are responsible for make payments toward the services they receive. This payment plan agreement authorizes GCMC to obtain and store your banking information and automatically charge (ACH) your account based on the terms below, on the mutually agreed date. Each new patient account will need a new completed payment plan agreement.

Account Balance	Balance Due	Minimum Monthly Payment
$100 and under	30 Days	Payment in full
$101-$300	3 months	Greater of $100 or 3 equal monthly payments
$301-$600	5 months	Greater of $100 or 5 equal monthly payments
$601-$1500	7 months	Greater of $100 or 7 equal monthly payments
$1501-$2400	10 months	Greater of $190 or 10 equal monthly payments
$2401-$5000	15 months	Greater of $220 or 15 equal monthly payments
Over $5001	18 months	Greater of $315 or 18 equal monthly payments

Monthly Debit Amount: _____ Payment Date: _____

Banking Institution (please include phone #): _____

Routing Number: _____

Account Number (please include a void check or deposit slip): _____

Failure to make the minimum monthly scheduled payment or pay the account in full by the terms above will result in the account being turned to our collection agency. This payment plan agreement rescinds any previously ACH agreements made with GCMC prior to September 12, 2023.

I agree to the terms of the payment plan agreement:

Patient/Guarantor Signature: _____ Date: _____

Printed Patient/Guarantor Name: _____