___North Colorado Medical Center
___Sterling Regional MedCenter
___Torrington Community Hospital
___Platte County Memorial Hospital

___McKee Medical Center
___East Morgan County Hospital
___Ogallala Community Hospital
___Washakie Medical Center

DATE: _____

PATIENT NAME:_____ ACCOUNT #:_____

Dear Patient or Responsible Party:

To obtain and secure the financial support necessary to maintain our hospital and maintain customer satisfaction through clinical quality and competitive value, it is the policy of the hospital to collect at the time of admission, or prior to discharge, the amount not covered by your insurance company.

Based on the information obtained from your insurance company, the following deposits will be due:

Your deductible amount of $_____
Your co-payment of $_____

Please check which payment method you prefer:

_____ Estimated balance in full $_____within 30 days

_____ Credit Card Payment: Expiration Date:_____

VISA#_____ $_____

MC#_____ $_____

_____ Equal monthly payments that follows hospital guidelines:

Balances under $100 = 2 equal monthly payments
$101-$200 = 4 equal monthly payments
$201 and above = 6 equal monthly payments

_____ Referred to Patient Accounts Financial Counselor for further assistance.

I acknowledge receipt of the above payment options and agree to its terms for the account listed above.

Signature:_____Date:_____
Witness:_____Date:_____