Uniontown Hospital EZPay Program
Financial Agreement Form

(A) Application and Program Information:

All information provided by the applicant will be considered and treated as confidential. Furthermore, this information will be used solely for the purpose of creating a financial agreement arrangement through the EZPay Program. The program will be administered by Penn Billing Services, 916 South 14th Street, Harrisburg, PA 17104, Phone: 1-800-900-1374. **All payments, correspondence and inquiries should be directed to Penn Billing Services.** There will be a $ 5.00 a month service fee applied to all months during the life of this arrangement.

(B) Guarantor Information: List person primarily responsible for maintaining agreement requirements.

Guarantor's Name:	Guarantor's Social Security Number:
Guarantor's Address:	Phone Number:
	Alternate Phone Number:
	Email Address:

(C) Agreement Includes: List all patient names and outstanding balances that will be included in this financial agreement.

Patient Name (s):	Account Number(s):	Admit Date (s):	Account Balance (s):
Total Account Balances to be applied to EZPay Program			

(D) Financial Agreement: List all information required to establish this financial agreement.

The purpose of the agreement sets forth the terms and conditions for the payment through Penn Billing Services of outstanding balances owed to Uniontown Hospital. Section A.

This agreement is made and entered into between Uniontown Hospital, located at 500 W. Berkeley, Uniontown, Pa 15401 and _____, residing at _____. Penn Billing Services will be acting on behalf of Uniontown Hospital. Section B.

This agreement concerns medical treatment that was provided to the patients listed in Section C in the amount of _____. This amount will now be referred to as the total account balance.

Uniontown Hospital agrees to accept:
a.) _____ monthly payments,
b.) each in the amount of _____ ,
c.) The payment will be due by the _____ of each month

The amount of _____ will be applied to the total account balance owed to Uniontown Hospital and the amount of _____ will be applied to the monthly service fee. If a monthly payment is missed, payment is made any day after the due date or payment is less than the monthly payment amount, the agreement will be considered in arrears.

This payment arrangement will allow for the total account balance (Section C) and the monthly service fee _____ to be satisfied in an amicable manner.

I acknowledge that by signing here I have agreed to pay Penn Billing Services (acting in accordance with Uniontown Hospital) the agreed upon terms set forth above. I understand that if I default on this arrangement I will not be eligible for future EZPay agreements. I also understand that if I default on this agreement it will be referred to a collection agency and reported against my credit history.

Signature of Applicant: _____ Date: _____

Signature of Financial Care Consultant: _____ Date: _____