



W o m e n M a k i n g H e a l t h C a r e A c c e s s i b l e

3435 North Sheffield Chicago, Illinois 60657 • Tel: 773 935 6126 • Fax: 773 935 7145
www.chicagowomenshealthcenter.org

Client Payment Agreement

Client name (print) _____ Date: _____

Please complete both pages before filling in this summary box!

I owe CWHC _____ I will pay _____ dollars per _____

Chicago Women’s Health Center is a not-for-profit organization. We are not a free clinic and do not receive government funding. To meet the needs of a diverse population we offer sliding scale fees and flexible payment plan options without requiring verification of income. Please pay as much as you can afford. The quoted minimum amount covers the lab and/or supply fees. To help us continue to meet our clients’ needs, we ask you to pay at least the minimum, if at all possible, and as much as you can towards the full fee. We offer you this option of paying over time on a schedule that is comfortable to you. If you need to change your plan, at any time, you may contact the billing department at 773.935.6126 ext 228. Your commitment to a payment plan allows us to keep our commitment to all of our clients to provide quality health services that are affordable to all women. Thank you for joining in our mission!

	Minimum	Suggested
A. Past Balance, if any:	_____	_____
B. Today’s Charges:	_____	_____
C. Today’s Payment, if any:	_____	_____
D. Remaining Total;	_____	_____
E. Total Amount I Intend to Pay: Use scale D as a guideline	_____	_____
F. Monthly Payment Amount: What is a reasonable amount you can afford monthly?	_____	_____

G. Number of Months _____
Divide E by F

H. Starting Date of: _____ /Ending Date of: _____

I. How Will You Pay?

___ Send monthly checks. *You may request dated self-addressed envelopes as payment reminders.*

___ Series of post-dated checks. How many checks submitted with form? _____

___ Series of authorized credit card payments.

VISA___ MC___ Card # _____ Expiration Date _____

___ Other. Please explain below in J.

J. Other terms, if any / Alternative Plans: _____

I am the party responsible for payment. I have read and agreed to the above payment plan. If I do not meet the above plan, I will be contacted by the CWHC billing department.

Signature _____ Date _____

Address: _____

City/State/Zip: _____

Phone # _____ Alternative # _____

If you have any questions or need help completing this form contact the billing department at 773.935.6126 ext. 228. Thanks for choosing a payment plan!