Lake Health District
Quality Care Close to Home

Lake District Hospital
Lake Health Clinic
Lake Health Specialty Clinic
Home Health & Hospice
Lake County Public Health
Lake District Wellness Center & Prevention

Patient Payment Plan

Lake District Hospital will accept monthly payments when all other payment options have been exhausted. The minimum monthly payment amount is based on the scheduled guidelines adopted by the Board of Directors.

Account Balance	Minimum Payment	Term of Payments
$50.00 or less	Payment in Full	At time of Service
$50.01 - $1,000	$83.00 Monthly	12 Months
$1,000.01 - $3,000	$167.00 Monthly	18 Months
$3,000.01 - $6,000	$250.00 Monthly	24 Months
$6,000.01 -$10,500	$300.00 Monthly	36 Months
$10,500.01 -$15,000	$400.00 Monthly	48 Months
$15,000.00 and above	$500.00 Monthly	60 Months

PLEASE NOTE: Because Lake District Hospital is supported by county tax dollars, the Board of Directors established the minimum payment guideline policy to remain impartial. The Patient Services Representative does NOT have the authority to deviate from the established minimum payment schedule. If your minimum payment exceeds 10% of the family income for a month, excluding deductions for essential living expenses or creates a financial hardship for you or your family, you are advised to complete an application for financial assistance. You can obtain an application Online or from the Patient Services.

Are claims still pending with insurance? ☐ Yes ☐ No

☐ INITIAL I understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed below and agree to pay the additional amount based on this plan as well.

An initial payment of 10% of the balance is required to meet monthly payment guidelines.

Date: _____ Patient Account No. _____ Patient Account Balance $ _____

10% Payment: $ _____ Min. Monthly Payment Amt $ _____ Calendar Day Payment Due _____

☐ INITIAL I hereby authorize Lake Health District to collect the Min. Monthly Payment Amount above on the Calendar Day Payment Due using my debit/credit card account provided below:

Type of Card: ☐ Mastercard ☐ Visa ☐ American Express ☐ Discover ☐ Payroll Deduction*

** Payroll deduction available for employees and contracted staff only.*

Account #: _____ Expiration Date: _____ Security Code: _____

Billing Address: _____ Billing Zip Code: _____

Important: It is my responsibility to notify Lake Health District, if my debit/credit card has Expired or if my patient balance has increased on my next statement. If your statement is received and a Date of Service has Finalized with Insurance, your statement will show the NEW patient liability amount in additional to your Min. Monthly Payment Amt above.

Any questions or concerns that I may have concerning this agreement were answered or discussed with one of the staff members at Lake Health District.

If this agreement needs to be altered at any time, I will contact the Business Office Manager at (541) 947-2114 Ext 435 or 5130 to discuss further options.

_____
Guarantor or Patient Printed Name

_____
Guarantor or Patient Signature

_____
Witness: Patient Services Lake Health District Signature