St. Clair County Community Mental Health Authority

# Hospital Inpatient
# Installment Payment Agreement

3111 Electric Ave.
Port Huron MI 48060
(810) 985-8900

Individual: _____ Case #: _____

Responsible Party: _____

Past Due Balance: **$**_____

I agree to pay **$**_____ per month until the past due amount as noted above is paid in full. Payment of balance shall not exceed 12 months, nor be less than $11.00 per month.

I agree to pay my first past due payment when this agreement is signed and to make all following payments **no later than the 5th working day of each month.** I understand that failure to remit timely payments may result in my account being turned over to a collection agency.

**Mail payments to:**
**S.C.C.C.M.H.A.**
**3111 Electric Ave.**
**Port Huron, MI 48060**

_____ _____
Individual/Guarantor Signature Date

_____ _____
Spouse Signature Date

_____ _____
Preparer Signature and Title Date

**cc:** **Individual/Responsible Party**
**E.H.R**
**Billing Coordinator/Designee**

Clinical Form: #03-0002A
Reviewed Date: 9/1/2023
Policy Ref: #03-002-0025, #07-003-0030, #07-003-0080
EHR: Administrative/Financial, Fee Determination/Payment Agreements, Residential Fee Determination