

St. Clair County Community Mental Health Authority

Outpatient

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.

In addition to this Installment Payment Agreement, payments for any current services (if applicable), will also be made monthly according to current invoice due dates. Installment Payments shall not exceed 12 months, nor be less than \$20.00 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.

Check which is applicable:

☐ **Individual is no longer receiving services**
(Payments should be made to St. Clair County Community Mental Health at the above address)

☐ **Individual is currently receiving services**
(Payments should be made to St. Clair County Community Mental Health at the above address)

Individual/Responsible Party Signature

Date

Preparer Signature and Title

Date

CC: Individual/Responsible Party
E.H.R
Administration Designee