



4390 Parliament Place, Suite R  
Lanham, MD 20706

800-824-6814

## PAYMENT PLAN AGREEMENT

### PATIENT INFORMATION

Last Name	First Name	SSN#
MR#	Transportation #	
Sending Facility		Receiving Facility
Mode of Transport: <input type="checkbox"/> Fixed Wing <input type="checkbox"/> Medical Escort <input type="checkbox"/> Helicopter <input type="checkbox"/> Ambulance <input type="checkbox"/> Wheelchair		

### GUARANTOR INFORMATION

Last Name	First Name	
Street Address		
City	State	Zip Code
Phone Number	SSN#	
Billing Address		
City	State	Zip Code

Total Charges _____	Total due per agreement _____	Monthly Payment Amount _____
Total Payments _____	Payment Start Date ____ / ____ / ____	

Send payments to:	Midatlantic Air Transport Service Box 632022 Baltimore, Maryland 21263-2022
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### Financial Agreement and Guarantee of Payment

In consideration of the above indicated transportation services to be rendered, the undersigned agrees to pay Washington Hospital Center Corp. d/b/a Midatlantic Air Transport Service in accordance with the regular rates indicated on this record. The undersigned acknowledges that Medicare does not cover wheelchair transportation services and that the claim will not be submitted to Medicare. If an account is referred to an attorney or collection agency, the undersigned shall pay, in addition to the outstanding balance due (i) attorney's fees of 15% (ii) collection expenses (iii) a charge of \$10.00 to cover expenses of photocopying and delivery and (iv) interest at the rate of 12% per annum from the date of discharge until paid in full on the unpaid balance of any amounts not paid within 30 days of billing. Please be aware that if you fail to make arrangements for payment, we will turn your account over to our legal services department.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness' Signature\* \_\_\_\_\_ Date \_\_\_\_\_

\*Witness is only verifying the signature of the guarantor and is *not* financially responsible for payments.