



4390 Parliament Place, Suite R  
Lanham, MD 20706

800-824-6814

### PROMISSORY NOTE

#### PATIENT INFORMATION

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

ESTIMATED TOTAL COST: \$ \_\_\_\_\_

#### 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.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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

Date \_\_\_\_\_

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