



Payment Plan Agreement

This Payment Plan Agreement is entered into by Millennium Health, LLC ("Millennium") and Patient

Name: _____

Date: _____

Millennium Account Number(s): _____ **(REQUIRED)**

Patient's physician ordered Millennium laboratory testing for Patient. As a result, Patient has been billed by Millennium in the amount of \$_____ (Insert Amount Owed).

Patient certifies that payment of this amount in full would be a financial hardship on patient; and therefore, Patient is entering into this Payment Plan Agreement in order to set up a payment plan for the amount owing to Millennium.

In consideration of Patient agreeing to make payments as set forth below, Millennium agrees to not send Patient's account to collections and to not charge interest on the outstanding amount due and owing to Millennium.

Patient agrees to pay the sum of \$_____ monthly* (by the 10th day of the month) until the balance is paid in full.

*Minimum Amount is \$50.00

This program is not insurance and is not intended to be a substitute for insurance.

Agreed to:

Patient Signature

Print Name

Submit this signed Agreement to:
Millennium Health, LLC
ATTN: Financial Support Department
P.O. BOX 841773, DALLAS, TX 75284-4468