Sawyer County
Payment Plan Agreement

Please mail completed form with first payment to:
Sawyer County Ambulance
10610 Main St. Suite 10
Hayward, Wi 54843

Facility: Sawyer County Ambulance Date: _____

Address: 10610 Main Street Suite 10 Hayward, WI 54843

Patient:

Address:

City/State/Zip:

E-mail:

I, the undersigned member, agree to make payments on the specified dates and the agreed amounts stated on the payment schedule below to Sawyer County Ambulance. I understand that should I fail to make payment on the scheduled payment date, this payment plan will terminate and I will immediately be responsible for paying any remaining balance in full. Penalties could include: accounts being turned over to collection agency, interception of your Tax Return and other collection procedures. Upon default, I agree to pay any fees and costs that the creditor may incur in collecting my balance owed.

Total amount owed (beginning balance) ..... $

Payment Date	Payment Amount	Balance

I agree that the above schedule of payments is an acceptable resolution to help retire my debt with Sawyer County Ambulance and I remain current with this payment plan.

Patient Signature Date Facility Representative Date