



**REQUEST FOR EXTENDED PAYMENT PLAN**

**Return Application within 10 days to: RCI  
PO Box 338  
Cedar Rapids, IA 52406-0338 or Fax to 319-832-1747**

Date of Application: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ Account Number \_\_\_\_\_  
Responsible Party (if different than patient): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_  
Patient's/Responsible Party's Adjusted Gross Monthly Income: \$ \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
If no income, how do you live? Live with relatives, etc. \_\_\_\_\_  
Number of people living in your household (family unit): \_\_\_\_\_  
Number of children living in the household 18 years or younger: \_\_\_\_\_  
Current unpaid balance: \$ \_\_\_\_\_  
*(Dollars will be divided equally between the monthly installments)*

**AVAILABLE PAYMENT PLAN OPTIONS:**

- 1) Please select an option from the list below. (  )
- 2) Please initial next to the plan you've selected.
- 3) Once you have made your selection, please read and sign the agreement below
- 4) Provide payment plan details on the next page *(how you will be making these payments)*

- \_\_\_\_\_ 3 monthly installments *(\$5.00 service fee applied)\**
- \_\_\_\_\_ 4 monthly installments *(\$10.00 service fee applied)\** (Unpaid balance must exceed \$200)
- \_\_\_\_\_ 5 monthly installments *(\$15.00 service fee applied)\** (Unpaid balance must exceed \$300)
- \_\_\_\_\_ 6 monthly installments *(\$20.00 service fee applied)\** (Unpaid balance must exceed \$400)

*\*If your account is delinquent (past 30 days aging) then you are already into a 2<sup>nd</sup> month plan and payment in full is recommended to avoid any penalty fee for late payment.*

Due to limited financial resources, payment in full to Radiology Consultants of Iowa for services rendered is not possible at this time. I hereby request an installment plan. I have provided the financial information necessary to process my request. I agree to pay the corresponding (one-time) service fee in exchange for the installment plan that I have selected. If payment is late it is considered a breach of the contract and the account balance, including service fees, is due immediately and may be sent to an outside collection agency. Any failed transactions (such as failed ACH, declined credit card, or NSF check) will also incur an additional \$30 service fee. Failed transaction fees can be avoided by calling prior to payment date to update the payment information. By signing below, I request and agree to the above payment plan.

\_\_\_\_\_ *Responsible Party* \_\_\_\_\_ *Date of Signature*

Plan Accepted by RCI Financial Department:

\_\_\_\_\_ *RCI Financial Representative* \_\_\_\_\_ *Date of Signature*

**PAYMENT PLAN DETAILS**

I have selected a payment plan option. This attachment provides details on how I elect to pay this monthly installment.

**Please select from one of the following payment options:**

1.  **Automatic Payment Plan.**

This is a convenient way to make your monthly payments. We receive our payment as authorized by you thru direct charge to your credit or debit card, checking account, or savings account. There are no checks for you to write. You won't have to remember to send your payment and risk a late payment which could result in an outside collection agency.

*"I authorize Radiology Consultants of Iowa, PLC to automatically withdraw monthly installment from my account each month until the balance due, including finance fees, are paid in full."*

Balance Due (not including finance fees which I understand will be applied and also withdrawn.) \$ \_\_\_\_\_  
Choose a specific day of the month for withdrawals: \_\_\_\_\_ (i.e. 15<sup>th</sup>)

MasterCard  Visa  Discover  American Express

Card Number \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

Security Code \_\_\_\_\_ Signature of Cardholder: \_\_\_\_\_

**Card and or account numbers will be blocked upon transaction confirmation to protect your information.**

OR

ACH – Checking Account  ACH – Savings Account

Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

**Routing and Checking Account Number**

The Routing Number is usually located between the  $\text{⑆}$  symbols on a check. (9 digits)

The Bank Account Number is usually located to the left of the  $\text{⑆}$  symbol on a check. (3-17 digits)

2.  **I decline automatic payment plan options.** I elect to send my payment via the mail, stop by the Business Office during normal business hours, or pay on-line through RCI web link. **I am aware that I will not receive a monthly statement. I am aware that RCI is not required to provide a courtesy reminder that this payment is due or past due.** I am responsible to make sure payment is received by the 15<sup>th</sup> day of each month and understand that a missed payment could mean my balance is transferred to an outside collection agency without further notice.

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date

**Please allow up to 5 days for processing this financial request. You will receive verification. Thank you.**