**Matthew J. McIlrath, D.C., C.M.U.A.**

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**PROMISE TO PAY AGREEMENT**

This agreement made and entered on this day, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, between Health One P.A. and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, for services rendered by Dr. Matthew McIlrath and or his associates of Health One P.A. I promise to pay Health One P.A. co-pays and deductibles applied by said insurance.

I agree to be responsible for any balance not covered by said insurances.

The payment will be effective after the final payment from said insurance.

You will be expected to pay the balance until paid in full and failure to comply may result in legal ramifications of this promissory note. You will be responsible to pay all legal fees from this point forward if your balance goes into default.

You may be offered a payment plan to make a payment agreement to pay the balance in full over an agreeable period of time.

Upon signing this promissory note you are agreeing to pay any balance owed to Health One P.A. and you understand the term and conditions to the promissory note.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_