

**P R O M I S S O R Y   N O T E**

This Promissory Note is entered into by:

\_\_\_\_\_ of \_\_\_\_\_  
(Responsible Party Name) (Street Address)

\_\_\_\_\_  
(City, State & Zip)

AND

Greensboro Women's Health Care of 719 Green Valley Road, Suite 101, Greensboro, NC 27408

The patient or responsible party agrees to pay the sum of \$ \_\_\_\_\_ to Greensboro Women's Health Care. Payments are to be made on a monthly basis beginning: \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ and continue monthly until paid in full. Patient and/or responsible party understands that balance may change due to other services rendered. Patient and/or responsible party also understands that payment must be made every thirty (30) days regardless of receipt of a statement. Patient and/or responsible party understands that any time payments are not made as required, account may be turned over to a collection agency with no further notice. Any and all fees assessed due to collection agency referral will be the responsibility of the patient and/or responsible party. Patient and/or responsible party understands that any Medicaid benefits are not a permissible form of payment now or in the future.

\_\_\_\_\_  
Patient or responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date