Cordova Community
MEDICAL CENTER

P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

PROMISSORY NOTE

Patient Name _____

Guarantor Name _____

Guarantor Address _____

_____

Guarantor Phone Number _____

Account Number(s) _____

The total amount due for all accounts _____ **to be paid in installments of**

_____ **beginning on** _____.

Frequency of payments
_____ **weekly**
_____ **twice monthly**
_____ **monthly**
Payment Method
_____ **cash/check**
_____ **credit card**

Credit Card holder name (as it appears on the card)_____
Credit Card holder mailing address _____
Credit card holder email address _____

Credit card number _____

Expiration date _____ **Security Code(on back of card)** _____**Zip Code** _____

Patient/Guarantor Signature _____ **Date** _____

Reviewed by _____ **Date** _____

If you are unable to make a scheduled payment, please contact the CCMC billing office, at 907-424-8227