



# THE NATIONAL MEDICAL CODING INSTITUTE

3355 LENOX ROAD, SUITE 242 ATLANTA, GA 30326  
OFFICE: 404-346-1701 or 404-346-1900 FAX: 404-759-2306

## PAYMENT ARRANGEMENTS FORM

This form must be completed and signed by both NMCI and the student in order for official payment arrangements to be honored by NMCI.

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

NMCI Course Fee: **\$1975.00** (includes course, workbook(s), study guide, AAPC student membership fee and certification exam)

By this promissory note, I \_\_\_\_\_ absolutely and unconditionally promise to pay to the order of NMCI the full amount of the course fee listed above. I understand that the course fee should be paid in full by mid-term and **there are no refunds after I attend one full class.**

Payment Schedule: The following schedule must demonstrate complete payment of the entire course fee by mid-term.

Date: _____	Amount \$ _____	Date: _____	Amount \$ _____
Date: _____	Amount \$ _____	Date: _____	Amount \$ _____

This note evidences my obligations to NMCI for the course. If I am late in making any payment, the entire balance may become immediately due and payable without demand. Any amounts not paid when due shall thereafter bear interest at the maximum legal rate per year, but in no event more than 8%. I further agree to pay all reasonable costs of collection of amounts due hereunder, including attorneys' fees, court costs, and all other associated costs.

If you wish to use a credit card to make payments, complete the following:

Credit Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

Important: I understand that failure to pay the stated agreed upon amount s listed on this form will result in a forfeiture of all funds previously applied to this balance and may also result in my dismissal from class. I further understand that dismissal from class as a result of failure to pay will not release me from my obligation to pay the entire balance to NMCI.

Requested by:

Accepted by:

\_\_\_\_\_  
Student (Print Name)

\_\_\_\_\_  
Belinda Stanley, CPC or Representative

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date