PAYMENT AGREEMENT

1. My name is _____ and I am hiring Bill Equity, LLC ("Bill Equity") for the purpose of negotiating a reduction in or correction of one or more legal bills or medical bills or hospital bills (the "Bills"). My best contact information is by the following method at the following email address or telephone number (please check and complete one or more):

☐ Fax to _____

☐ Call to _____

☐ Text to _____

☐ Email to _____

2. I understand and agree that medical bills may be covered by HIPAA and accordingly I have signed and delivered to Bill Equity a HIPAA Waiver. I understand and agree that any legal bills I provide and information about my legal matters are not confidential.

3. I understand that Bill Equity might be asked by the billing agency questions about my ability to pay my medical bills, and questions about how many medical bills I have had during a specific time period. I agree to promptly provide Bill Equity with honest answers to those questions, and hereby indemnify Bill Equity and its agents and employees and agree to hold such parties harmless in the event I provide false information or false answers to these questions.

4. I understand that in some cases, medical or legal bill providers engage collection agencies to collect medical or legal bills. Although Bill Equity will use all reasonable efforts to complete bill negotiation prior to the time any bill is sent to collection, I understand that Bill Equity is unable to control that process, and that if bills are turned over to collection agencies, that might adversely impact my credit score. I hereby acknowledge and accept that risk.

5. I understand that as soon as Bill Equity advises me that a Bill has been successfully negotiated, I must immediately pay the Bill, and that failure to do so might result in collection actions against me by the Bill provider.

6. I understand that by signing this agreement where indicated below, I am agreeing to pay Bill Equity ____% of the amount of the reduction of the Bill or Bills that Bill Equity has been hired to negotiate. If there is no reduction in the amount of the Bill, I will not be required to make any payment to Bill Equity.

7. In the event a payment is due to Bill Equity because a Bill has been successfully reduced, such payment shall be due and payable as soon as the invoice is sent to me by Bill Equity. I understand that Bill Equity may engage in collection actions in the event its invoice is not promptly paid, and may also cease all work being performed on my behalf. In the event Bill Equity so requests, I will agree to provide partial advance payment to Bill Equity, and permit amounts held by Bill Equity to be applied to Bill Equity's charges.

6. I understand that the information released in response to this authorization may be re-disclosed to other parties by the billing companies or to other employees or independent contractors of Bill Equity.

Print Client Name: _____

Signature of Client: _____

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Name and Relationship of Legally Authorized Representative to Client, if This Waiver is Being Signed by Someone Other Than Medical Patient:

Print Representative Name: _____

Describe Relationship: _____

Date: _____