GAFFAR SYED, M.D. P.A.

Financial Notice:

I authorize my insurance benefits be paid directly to Gaffar Syed, M.D. P.A. I understand that I am financially responsible for any balance. I also understand it is my responsibility to keep Gaffar Syed, M.D. P.A. updated on any changes in my insurance information, Shall I fail to do so and the time limit has lapsed to file my claim with my insurance carrier I will be responsible for payment or services. I also authorize Gaffar Syed, M.D. P.A. to release any information required to process my claims. ANY UNPAID BALANCE WILL BE ASSESSED INTEREST OF 24% AND ANY FEES ASSOCIATED WITH PUTTING THE CLAIMS IN COLLECTIONS, INCLUDING BUT NOT LIMITED TO, ATTORNEY FEES, COURT COSTS, COLLECTIONS FEES AND INTEREST.

Patient Signature: _____(Seal)

Date: _____

OFFICE USE ONLY

Witness Signature: _____Date: _____

Printed Name: _____