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Endocrinologist

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Your signature below forms a binding agreement between, on the one hand, SARAH FISHMAN, M.D. PhD PC (the "Practice") and, on the other hand, the undersigned Patient who is receiving medical services or the undersigned Responsible Party for patients under 18 years old or holding other legal representative status. The Responsible Party is the individual who is financially responsible for payment of medical bills. This includes all fees for medical visits, procedures, and tele-health communications.

Payment Due in Full at the Time of Service:
All charges for services rendered are due and payable in full at the time of service, regardless of whether you have insurance. You hereby waive any and all claims against Practice with respect to the processing of insurance claims and the payment of benefits from the insurance company to you.
Acceptable payment methods include cash, credit card or check.

Returned Check Policy:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 check service charge. Once notice is received of the returned check, Practice will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 check service charge.

Missed Appointments and Late Cancellations:
You will be charged a fee of **$75.00** if you miss an appointment or fail to cancel an appointment at least 24 hours prior to your scheduled visit. If you fail to appear for your appointment within 20 minutes after the scheduled time, the appointment will be considered missed without appropriate cancellation and you will be subject to a fee of $75.00. You must pay this balance in full at the time of your next appointment.

Non-Payment on Account:
Should collection proceedings or other legal action become necessary to collect an overdue account and missed appointments/late cancellations, the Patient or the Patient's Responsible Party understands that Practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at a 18% per annum (or the highest rate permitted by law, if lesser), all court costs and attorneys' fees, and collection fees, which will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms. A photocopy of this document shall be as effective and valid as the original.

_____ ____/____/____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____
Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.