Mohammed Ahmad, MD

FINANCIAL AGREEMENT

Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

IF APPLICABLE:

Guarantor's Name: _____

Guarantor's Date of Birth: _____ Guarantor's Social Security Number:_____

DISCLOSURES AND CONSENTS:

Assignment of insurance Benefits:

I hereby authorize direct payment of my insurance benefits to Mohammed Ahmad, MD's affiliated professional associations or the physician individually for services rendered to my dependents or me by the physician or under his supervision. I understand it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any copay or balance due that Mohammed Ahmad, MD is unable to collect from my insurance carrier for whatsoever reason.

Medicare/Medicaid Insurance Benefits:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's, authorized benefits be made directly to Mohammed Ahmad, MD's affiliated professional associations or the physician on my behalf.

Lab/X-Ray/Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any copay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

FINANCIAL RESPONSIBILITY AGREEMENT:

I understand and agree that I am, and will be, financially responsible for any and all charges for services not paid by my insurance. This may include medical services/physician visit, preventative exam/physical, lab testing, EKG, and any other screening or diagnostic testing ordered by the physician.

I understand and agree it is my responsibility to know insurance benefits for services done in the office and ordered by the physician.

I understand and agree it is my responsibility to recognize the physician is contracted with my insurance and I have verified the physician is an "in network provider" through my insurance. If the physician is not contracted or considered an "out of network provider", my insurance benefits may be reduced or denied and I will become financially responsible for any unpaid amounts.

I understand and agree that Mohammed Ahmad, MD, or authorized agents, will be able to contact me electronically and vial phone in order to collect balance accrued from previous dates of service.

All balances are due upon receipt of a patient invoice, and no later than 30 days from the date of the invoice. If Mohammed Ahmad, MD. must pursue legal action against patient to collect any amounts owed by patient to Mohammed Ahmad, MD, patient agrees to pay Mohammed Ahmad, MD's expenses, including reasonable attorneys' fees incurred as a result of the legal action.

I understand and agree that payment for the above services, including deductibles, co-insurance, co-payments, based on usual and customary fees, is due, in full, at the tie of service.

_____ _____

Patient Signature Date

_____ _____ _____

Guarantor Signature Relationship to Patient Date