Lee A. Kleiman, M.D., F.A.C.S.

PAYMENT TERMS

Patient Name: ____ **DOB:** _____________________

I hereby assign any and all insurance benefits due and payable to me by any policy of insurance or reimbursement plan to Severn River ENT for services rendered. I further understand and agree that this assignment is non-revocable.

I understand and agree that without an authorization or referral at the time of service from my HMO/IPA/POS, I will be financially responsible for any charges I incur. If I am a member of an HMO, I agree to execute a separate out of plan of release when requested to do so.

I understand that I personally guarantee to be financially responsible for any and all permitted charges not covered by the assignment. As the Guarantor, I fully accept the medical services provided to the above named patient as full consideration for my signing this document.

I have fully read and reviewed this document and I will execute it with full knowledge and understanding of its contents. If any balances remain open and it is necessary to refer the account for collection, I agree to be responsible for all cost of collection including attorney fees of twenty-five percent (25%) of any balance due.

This applies to all services provided for the year ________________________________.

____ _______________________ __________________

Signature of Patient if Over 18 years old **Witness Initials** **Date**

If the patient is a minor (under 18 years of age), a parent and/or guarantor please fill our the section below.

Parent/Guarantor Name: ________________________________ **DOB:** __________________________

Relationship to Patient: __________________________________

____ _________________ _________________

Signature of Parent/Guarantor **Witness Initials** **Date**