

COMPREHENSIVE PAIN MANAGEMENT
3870 Medical Park Drive
Austell, Georgia 30106
(770) 948-6824

SELF-PAY AGREEMENT

A 50% (fifty percent) deposit is required followed by monthly payment arrangements for the balance not to exceed 12 months.

Today's Date: _____

Patient Name: _____ Account #: _____

Date of Service: _____

Previous Balance: _____

Today's Payment: _____ Balance: \$ _____

Monthly Payment: _____ Date Payments Due: _____

1. Payments are to be made in monthly installments (**no payment notices will be sent**) the date payment is due will be determined at the time the agreement is signed.
2. If payment is not made, you will not be seen by the physician
3. If payment is not made for 2 (two) consecutive months the agreement will be considered null and void and you will be notified in writing requesting the balance to be paid in full within 5 (five) days.
4. If payment is not made for 3 (three) consecutive months the patient will be dismissed from the practice for failure to pay and will be turned over to collections.

THIS IS A FINAL AGREEMENT. NO OTHER AGREEMENTS WILL BE MADE.

I have read and understand the contents of this agreement and I agree to the terms.

Signature of Patient or Responsible Party

Date

Witness