

.Noor J. Ferrell, D.O. PLLC
77 Sugar Creek Center Blvd, Suite 206
Sugar Land, TX 77478

PATIENT INFORMATION REGARDING PROFESSIONAL FEES

The purpose of this agreement is to clarify your financial responsibilities and allow us to focus on what is most important to all of us—helping you.

Payment is expected at the time of service. Accepted methods of payment include cash, check, and credit card (Visa, MasterCard, American Express, Discover). **Checks should be made payable to Noor J. Ferrell, DO, PLLC.** Having the office charge your credit card at the time of service is encouraged because it simplifies the checkout process for you and the office.

I authorize Noor J. Ferrell, D.O. PLLC to charge my credit card.

My credit card # is _____ Auth # _____ exp. date _____

zip _____. (Note**Zip code must be for where the credit card statement is sent to.)

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. I am aware that insurance will not reimburse charges for missed appointments or late cancellations.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE TO THIS OFFICE ALL INFORMATION NECESSARY TO OBTAIN PREAUTHORIZATION PRIOR TO TREATMENT. I understand I may be charged for the time involved in obtaining preauthorization.

I agree to advise Dr. Ferrell when I come in of any change in my address, phone number, marital status or responsible party that has occurred since my last appointment.

THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED IS YOUR RESPONSIBILITY AND INSURANCE IS FOR YOUR REIMBURSEMENT. We do not bill the insurance company directly. Your statement contains all information needed to file with your insurance.

Although interest will not be charged routinely, we reserve the right to charge interest at the rate of 10% per annum and bill for all expenses incurred if your account has to be turned over to collections and/or an attorney. Similarly, we will charge to recoup returned check fees.

If you have any questions regarding this agreement, do not hesitate to discuss it with your doctor.

Patient's Name (Print) Date

Responsible Party's Name (if patient, indicate "self") Date

Responsible Party's Signature Date