Usal Cosmetic Surgery Center

305 Route 17 South Unit 3-100A Paramus, NJ 07652 • Phone: (201) 967 9200 • Fax: (201) 967 8300

Payment Agreement

Patient: _____ please be advised all payment/s for services rendered (Emergency Room and or Office Visits) by Dr. Hakan Usal M.D. should be submitted.

Your insurance carrier may be sending payment directly to you. If so, payment needs to be submitted to the office.

I, _____ (Patient or Legal Guardian) authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

_____ _____ Insured's or Authorized Persons

Signature Date

NOTE:

- We do not participate with your insurance carrier.
- We will review each covered service paid by your insurance company on an individual basis regarding any balance adjustments.
- You are responsible for all payment/s to the provider from your insurance company.
- Our Office will work with patients on an individual basis regarding any open balances. I understand in case of default on my part, and it is necessary for Usal Cosmetic Surgery or its agents to employ legal/collection council, I am responsible for collection charges incurred, which may be added to my bill.

Please **READ** and **SIGN** this policy.

X_____ Signature of Patient or Legal Guardian Date

Witness_____