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SELF PAY PATIENT

Date: _____

Discounted Self Pay Rate for Office Visit which **must be paid in full at the time of the visit.**

\$150.00 for new patient; \$100.00 for established patient.

In the event, that the Doctor and patient agree to a procedure in the office, this will reflect additional charges unable to be quoted prior to the visit.

Additional charges in the office due to an unplanned procedure may be paid on a monthly basis at the discounted rate established between the patient and the billing department. Discounted rates on surgeries will need paid within 90 days from the date of the surgery. No discount will be available on unpaid balance past 90 days.

Procedure: _____

Procedure: _____

Procedure: _____

Procedure: _____

We accept Care Credit and prefer it on all surgeries if patient is applicable.

Patient Name Printed: _____ Date of Birth: _____

Patient Signature: _____