PLEASE DO NOT WRITE ON THIS PAGE

Acknowledgement of Financial Responsibility

I hereby authorize Raja M. Din, MD PLLC to release information requested by my insurance carrier, or any person, company or agency responsible for processing claims for my medical services. I authorize direct payment to Dr. Raja M. Mohi-ud-Din, (either individually or as Raja M. Din, M.D. PLLC) by all insurances or any health plan whose benefits are otherwise payable to me up to the full balance of my medical bills.

I acknowledge that I am FULLY RESPONSIBLE for charges **not** paid by my insurance(s), or other agency(ies). These charges may include but are not limited to: co-pays, total balances, and collection fees. These collection fees may include attorney fees, court costs, third party billing/credit reporting costs, and may be based on a percentage at a maximum of 25% of the debt.

I understand that I am responsible for providing a referral, if required, at the time of service. **If my insurance denies payment for not providing a referral, I am responsible for all costs.**

Dr. Raja M. Din, M.D. PLLC accepts cash, checks, and major credit/debit cards. There is an additional $35.00 fee for returned checks, which will be added to any existing balance**. I acknowledge that I will be charged a $50.00 fee for office appointments not cancelled within 24-hours of appointment time and/or for same day cancellations. A $100.00 fee will also be assessed for NO SHOW or procedure appointments not cancelled within three (3) business days** of scheduled appointment time.

I consent to receive phone calls, voice messages or text message communications to the mobile phone number provided to this practice. I understand that I may be charged message and data rates by my wireless carrier. Such calls or messages may be generated by an automated messaging system and I may opt-out of this service by replying STOP to any message. Calls and messages may be from a human being or auto-dialer, related to appointment reminders, healthcare information and billing matters.

By checking and initialing on my demographic form, I acknowledged receipt of, and agreement to this practice's patient financial responsibility policy.

PLEASE ✓ BOX AND INITIAL ON PATIENT DEMOGRAPHIC FORM