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) (To include but not limited to: co-pays, total balances, attorney fees, court costs, third party billing/credit reporting, and collection fees).

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 $30.00 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.

By signing below, I acknowledged receipt of, and agreement to this practice's patient financial responsibility policy.

Printed Patient Name	Signature of Patient	Date