Arsalan Malik, MD, Inc., 2730 Wilshire Blvd, Suite 630 Santa Monica, CA 90403

PAYMENT AGREEMENT

Dear Patient,

Though you may have already verbally agreed to pay Dr. Malik for his services we would like to have a record of this understanding. The purpose of this agreement is to clarify your financial responsibilities and allow us to focus on what is most important – helping you. This will acknowledge that you are aware of being responsible for the full fee and that payment is expected at the time of delivery of service.

You can pay by cash, check, or credit card. Checks should be made to **Arsalan Malik, M.D., Inc.** since the office account is in the corporate name.

I authorize Arsalan Malik, M.D., Inc. to charge my credit card.

My credit card # is _____ Auth #_____exp. date _____ zip_____
My billing address is _____
(**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 agree to advise the office when I come in of any change in my address, phone number or responsible party that has occurred since my last appointment.

I UNDERSTAND THAT DR. MALIK IS NOT A PROVIDER FOR ANY HMO/PPO AND THAT I AM RESPONSIBLE FOR PAYMENT FOR HIS SERVICES. THIS WAS MY UNDERSTANDING AT THE TIME SERVICE WAS FIRST INITIATED. Dr. Malik will not bill the insurance company directly. Your statement contains the information needed to file your insurance for you personal reimbursement.

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

_____ _____
Patient's Name Date

_____ _____
Responsible Party's Name (Print) Date

_____ _____
Responsible Party's Signature Date