William M. Hudson, M.D. PC

Self Pay Agreement Form

Welcome to Hudson Cardiology. Our professional staff is committed to your treatment being successful. The following is a statement of our Self Pay Financial Policy, which we require you read and sign prior to receiving treatment.

I understand, as a self-pay patient, that I have the following options for paying my account balance:

- ○ I can pay the bill at the time of service (and receive a discount).
- ○ I can set-up monthly payment arrangements.

If I agree to pay my bill at the time of service, I understand that I will be eligible for a discount. *The discounted rate available is that of William M. Hudson, M.D. PC largest contracted insurance carrier.*

I prefer that my discounted account balance be charged to my Visa, MasterCard, Discover, or American Express **within ten (10) days**.

Form of Payment Using for Payment: ☐ **Cash** ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Credit Card Number: _____

Expiration Date: _____/_____/_____ **Signature:** _____

I understand that if I can't meet the guidelines listed above for payment on my account, I can arrange a payment plan that I can afford.

Patient Due Amount	Minimum Acceptable Payment
$50 or less	Entire Amount Due
$50-$250	$25.00 a month
$251-$500	$50.00 a month
$501-$750	$75.00 a month
$751-$1,500	$100.00 a month
$1,501-$2,500	$150.00 a month
$2,501 or more	$200.00 a month

Authorization & Release

I have read and fully understand the Self Pay Financial Form as outlined above. In the event that is necessary to turn my account over to collection I will also be responsible for any and all costs of collection.

I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I assumed responsibility by signing below, from this date forward until it has been revoked in writing.

_____ _____

Patient Signature Date

_____

Printed Patient Name

_____ _____

Witness (Staff) Date