Gregory A. Hanissian, MD
2101 Merchants Row, Ste 3
Germantown, TN 38138
p 901 751-9696
f 901 757-8960

a division of consolidated medical practices of memphis, pllc

TERMS AND PAYMENT AGREEMENT

Patient Name: ____

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THE FOLLOWING STATEMENTS:

1. I am responsible for all co-pays and deductibles not covered by insurance.
2. Ninety days following all doctors' visits at Hanissian Allergy (a division of CMPM) my total bill should be paid, and it will be considered delinquent, and may be turned over to a collection agency.
3. If my (or my dependent's account) is turned over to a collection agency, it is my full financial responsibility to pay all court costs, collection fees, and/or attorney fees. There will be no medical services rendered until the account or accounts are paid in full.
4. If we are not informed of any special requirement in your insurance contract for in-office or out-patient diagnostic testing or laboratory, testing may be performed that may be either out-of-network or not covered by your insurance carrier. Those charges are your responsibility. *Hanissian Allergy (CMPM) is not liable for charges for outpatient diagnostic testing or outpatient laboratory testing.*
5. I have been offered a copy of the document titled "Information for New Patients" at the time of my first visit.
6. If I fail to sign this form ***as it is written***, Hanissian Allergy will be unable to provide any further health care services to me.

By my signature, I have read and fully understand the above terms and payment agreement.

Signature of Patient or Guarantor:____

Print Name: ____

____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.

Date Signed:____

wwww.memphisallergist.com