UTHealth
East Texas Physicians

FINANCIAL AGREEMENT

For Professional Services Rendered or To Be Rendered

Patient:_____ DOB:_____ Responsible Party:_____

Address: _____

City, State, Zip:_____

Home Phone #:_____ Mobile #:_____ Work Phone #:_____

Account #:_____ Dates of Service: _____

Provider:_____

Estimated Fees for services rendered	$
Less Estimated Insurance (if applicable) –These are estimated benefits only	$
Past Due Balances (including previous bad debt or small balance adjustments)	$
Less Down-Payment (initial payment due when services are rendered)	$
Unpaid Balance (Amouunt Financed)	$

Responsible party hereby agrees to pay "Unpaid Balance" in _____ installments of $_____ each, due on the _____ day of every month. Failure to make timely payments may result in your account being placed with an outside agency. Any cost incurred to collect this debt will be at the expense of the patient.

You are entitled to an exact copy of this Agreement. You have the right at any time to prepay the Unpaid Balance under this Agreement. Any insurance benefits applied to this Agreement are estimated benefits only. If these change for any reason, you will be responsible for any difference.

By my signature below, I hereby agree to all terms outlined above.

_____ _____

Signature of Patient (or responsible party if patient is a minor) Date

_____ _____

Signature of Representative Date