* REQUIRED INFORMATION

SELF PAY PATIENT PAYMENT AGREEMENT

☐ I understand that I will be responsible for all charges related to the services provided to me by **Consortium Health and Rehab Center**.

☐ I understand that the charges presented to me are due in full on the day of service, unless arrangements have been made with the provider. I also understand that these charges are solely in relation to the professional services provided by the provider.

The patient certifies that he/she read and agreed to the forgoing, received a copy thereof, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

PATIENT NAME *

Enter name here

SIGNATURE *

DATE