

CARY CARDIOLOGY, P.A.

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PATIENT BUDGET PLAN AGREEMENT

Patient Name:	_____	Patient Account:	_____
Mailing Address:	_____ _____		
Phone/Cell:	() _____	() _____	
Insurance Info:	_____		
Total Balance:	\$ _____	Effective Date:	_____
Payment Today:	\$ _____	Monthly Payment(s):	\$ _____

I, the patient of Cary Cardiology, PA have been informed and concur that today's agreement will be in force until the Total balance is PAID IN FULL. Delinquent payments may VOID this agreement and I may be subject to any collection actions required to collect this balance in full if the account becomes delinquent and/or outstanding.

I understand that any additional charges incurred by me, prior to the balance being paid in full, will be added to the prior balance, unless I notify Cary Cardiology P.A. in writing and make a full payment .

_____ Signature of patient (or responsible party)	_____ Date
_____ Signature of Cary Cardiology employee witnessing	_____ Date

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