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Financial Agreement

We charge \$ 25.00 for any returned checks.

In case of your nonpayment of bills that are your responsibility (according to your insurance company or if you do not have insurance coverage), you will be responsible for any collection agency, attorney, and/or court costs incurred in our attempt to receive payment.

We accept cash, check, Master Card, and Visa.

I have read the above **financial agreement** and the **insurance authorization** sheet and agree to abide by these.

Name (print) _____
(patient or legal guardian)

Signature _____ Date _____
(patient or legal guardian)