CARDIOTHORACIC SURGICAL SPECIALISTS
1245 BRACE ROAD
CHERRY HILL, NJ 08034
DR AMRIT NAYAR

Financial Agreement

I_____will be financially responsible for all deductibles/copays and balance due for all treatment rendered to me by Amrit P Nayar, MD.

I therefore, authorize Cardiothoracic Surgicial Specialists of Cherry Hill, NJ (Amrit P Nayar, MD), to submit my credit card for the balance of above services.

Credit Card: Visa __ Master Card ___ Discover ___ American Express ____

Credit Card Number_____

Expiration Date_____

Security Code (3 digits on back of card)_____

This information will only be submitted if there is a balance due after your Insurance company has made payment. You will be promptly notified by Telephone/Mail of any or all charges to this credit card.

_____

(Print Name) (Signature)

(Date) (Witness Signature)

If Not Patient
I _____, authorized representative for the above listed patient will take full responsibility for all fees that are not paid.

_____

(Print Name) (Signature)

_____

(Date) (Witness Signature)