



CLAREMONT
MEDICAL CENTER

FINANCIAL AGREEMENT

I hereby agree that in consideration for services to be rendered by Dr. Mohitkumar Ardeshana, I shall make prompt payment of any Co-Pays, Deductibles, and Percentages due at the time of service. In the event my account becomes delinquent I agree to pay interest at the legal rate. I also agree to pay for collection expense if it becomes necessary for delinquent account to be referred for collection activity. If my insurance coverage is terminated, I accept responsibility for balances/ payments due after termination.

Patient Signature: _____

Date: _____