|  |  |  |
| --- | --- | --- |
|  | | |
|  | | |
| {{patient2.name}} |  | |
| Phone: {{patient2.phone}} |  | |
| Fax: {{patient2.fax}} |  | |
| Patient Name: {{patient.name}} |  | |
| Patient DOB: {{patient.DOB}} |  | |
| Patient ID: {{patient.id}} |  | |
|  |  | |
| {{patient2.name}} |  | |
| Southeast Neuroscience Center does not accept guarantee of payment out of settlement on attorney sponsored cases. It is our office policy that one hundred percent (100%) of the cost of the initial consultation and/or any diagnostic testing B companied with the signed agreement. | | |
|  |  | |
| {{table}} | | |
| **Agreement** | | |
| I, {{patient2.name}}, have enclosed a check in the amount of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ made payable to Southeast Neuroscience Center, I further agree that payment for follow up visits be paid within thirty (30) days of the scheduled service if payment for scheduled follow up visit surpasses the designated time frame a penalty fee and the amount of ten percent (10%) of the visit balance will be assessed with an additional one and one-half percent (1.5%) monthly until balance paid in full. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| {{patient2.name}} | | Date |
| Please return this signed, dated agreement to our office along with the check | | |
|  | | |
| Sincerely, | | |
| {{userName}} | | |
| {{userName}} | | |
| {{userTitle}} | | |

{{locationOfCare.address}}

{{locationOfCare.phone}}

{{locationOfCare.fax}}