# Ziyad H Mugharbil, MD

Urology Practice

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*Blairsville, GA 30512*

*110 Main Street*
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*Hiawassee, GA 30546*


# Payment Plan Agreement

Patient Name: _____

Patient Date of Birth: ___/___/___ Patient Social Security #: _____-____-_____

Person Responsible for payment: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home telephone: ____/____-_____ Work telephone: ____/____-_____

I agree to pay Dr. Mugharbil monthly payments of $_____ until such time as the account has been paid in full.

I understand that as my treatment continues, the balance on this account will increase. I may request written estimates of the cost of any/all treatment.

In the vent the account should become delinquent for a period of thirty (30) days, I hereby acknowledge that I will be responsible for all of the balance, court costs, and/or attorney fees.

I hereby certify that I have read and received a copy of this agreement as indicated by my signature and the date below.

_____ ____/____/____

Signature of Patient/Responsible Party Date

_____ ____/____/____

Signature of Patient's Spouse /Responsible Party's Spouse Date

Revised: 01/11/07