Sharon J. Littzi, M.D.
1 Morse Court
New Canaan, CT 06840
203-966-2336
www.sharonlittzimd.com

Patient Financial Responsibility Agreement

With your signature below you are also authorizing Sharon J.Littzi, M.D.'s office to charge your credit card for the following:

Payment for services is due the day services are rendered. I understand that all balances owed by me must be paid in full within 30 days from the date of my bill. If payment is made later than 30 days from the billing date, I understand that I am responsible for interest charges, which will accrue at arate of 1.5% per month.

I am also responsible for any courts fees, collection agency fees, attorney's fees and any other costs associated with collecting this bill or any of my bills in the future should I fail to remit any amounts due to Sharon J. Littzi, M.D.. If a check I issue Sharon J. Littzi, M.D. is returned unpaid by may bank for any reason, I agree to be responsible for a returned check charge of $45.00.

I am aware that Sharon J. Littzi, M.D. cannot accept the responsibility of collecting my insurance benefits. I am directly responsible to Sharon J. Littzi, M.D. for the payment of all balances due.

All managed care companies require co-payments to be paid on the date of service. Copays not paid at the time of service will be charged a $20 copay fee.

If I or any person whose bill I am responsible for fails to give 24-hour notice of appointment cancellation, I consent to being billed for that time at the rate of $50.00 per hour.

Any unopened products that are returned to our office will be charged a $10.00 processing fee per product. Opened products can be returned within 1 WEEK of purchase.

We will need a credit card number to be on file with us because of patient deductibles, balance from insurance payments, co-pay's, insurance cancellations or any other charges not covered or paid at the time of service.

Your signature below authorizes us to charge your credit card for any balance due as a result of services rendered in our office. A receipt and bill be submitted to you each time any charges are applied. All credit card information will be kept confidential and no other party outside our office will have access to this information.

Thank you for your consideration and understanding. If you have any questions, please do not hesitate to contact the office manager at 203-966-2336.

Credit card Number: Visa/MC _____-_____-_____-_____
Expiration Date_____/_____

_____ _____
Signature Date