Elhosn Eye & Aesthetics

Ramsey Elhosn, MD

Patient Payment Agreement

Thank you for the opportunity to help you meet your healthcare goals. During our discussion of your treatment recommendation and our Written Financial Policy, the following financial arrangements were made:

The estimated cost for your procedure is $____________.
(Patient initials)

As you know, it is this practice's policy to receive payment prior to your surgery. You have agreed to pay the treatment fee in the following way:

- Payment in full in the amount of $______________

  Paid with: _________________________________

- Deposit required: $__________________________

  Deposit paid with: ___________________________

If you have questions about your vision care or the choice of payment options, please do not hesitate to ask. We are here to help you get the quality vision care you want or need.

We look forward to seeing you at your scheduled appointment on ______________________

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

2 Executive Park Dr • Albany, NY 12203 • 518-487-4200 • 518-708-6896 Fax