LILIYA GERSHENGOREN M.D.

Liliya Gershengoren MD, MPH
Email: gershengorenMD@gmail.com
Tel: 908-840-8814
Website: DrGershengoren.com

Financial Agreement

Patient Name: _____ **Birthdate:** _____

I am authorizing Dr. Liliya Gershengoren to charge my credit card in the event that I fail to show for a scheduled appointment as recorded on my bill, or do not notify Dr. Gershengoren of my inability to attend a scheduled appointment at least 48 business hours in advance.

Furthermore, for outstanding payments of services rendered, I authorize Dr. Gershengoren to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than 48 hours business hours in advance. If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I authorize Dr. Gershengoren to disclose information about my attendance/cancellation to my credit card company if I dispute a charge. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Gershengoren for the collection of the past due account shall be my obligation as well.

To ensure the solvency of Liliya Gershengoren M.D. the following credit card information will be on file. As is the case with most clients, fees are charged to the credit after appointments, but I may alternatively make payments by check or Zelle at the time of service, in which case the card will not be charged. I understand that the credit card will not be charged unless the following conditions apply: no show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (e.g. appointment session) without payment rendered.

Cardholder Name: _____

Card Type (please circle): VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Number: _____ Expiration date: _____

V-code (3-digit code on back of card): _____

Billing Address: _____

_____ _____

Signature of patient **Date**