Ronaldmossmd92024@gmail.com

Ronald B. Moss. MD

Phone: 760-436-6404

Fax: 760-462-3986

Date of Service._____

Patient name:

_____

Date of Birth: _____

I agree to be responsible for any payments owed for services rendered not covered by my insurance company including deductibles or if provider is out of network.

Any such payments not paid by my insurance company will be billed directly to my credit card.

I agree also to a $65.00 cancellation fee if I do not cancel my appointment on-line within 24 hours of the appointment.

_____

Signature of Financially Responsible Party

Credit -Card information:

Name on Card: _____

Number: _____

Expiration Date:_____

CVV Code: _____