



ATELIER HEALTH

CARDIOVASCULAR MEDICINE | INTERNAL MEDICINE

ANNUAL FEE MEDICARE OR ≥ 65 PAYMENT

The payment options are by personal check, credit card, or debit card.

Payment in full at time of signing this Agreement and totaling \$_____

Patient authorizes the Private Practice to charge any fee installments on the above-referenced credit card until such authorization is revoked by Patient or this Agreement is terminated. Patient may elect to authorize additional billing fees for professional services from the above-referenced credit card.

Patient is financially responsible for all co-payments, co-insurance and deductible amounts under any of Patient's Plans. Patient will be billed immediately upon service and credit card charged within thirty (30) days of such billing for: 1) any fees not collected at the time of health care service; 2) co-insurance and deductibles for Private Practice health care services provided; and 3) charges for health care services provided not covered by Patient's medical benefits plan provider.

The Annual Fee is charged for patient to secure amenities not covered by patient's plan. The Annual Fee does not cover the cost and charges for private practice healthcare medical services provided. Patient shall be financially responsible for all private practice physician services charges. Some healthcare services provided by the private practice may not be covered by patient's plan, and patient will be solely financially responsible for those charges. As a courtesy, private practice will bill patient's plan for healthcare services provided by the private practice physician or staff that are covered by patient's plan. Under no circumstances shall the private practice charge patient personally for any healthcare services covered by Medicare or patient's plan. Private practice does not participate in any HMO plan.

Patient's enrollment participation in the private practice shall be completed with the execution of this agreement by each patient and responsible party, and the receipt of the practice fee. This agreement shall be governed by the laws of the State of California without application of choice-of-law principles. This agreement replaces and supersedes all prior agreements between patient and the private practice or Dr. Ram Dandillaya. This agreement may not be modified absent a writing signed by patient and an authorized representative of the private practice. If any term of this agreement is deemed invalid or in violation of any superseding law or policy, the remaining terms of this agreement shall remain in full force and effect. A photocopy or digital



ATELIER HEALTH

CARDIOVASCULAR MEDICINE | INTERNAL MEDICINE

copy of the signed original of this agreement may be used by the patient or the medical practice for all present and future purposes.

SIGNED BY

For each participating patient over the age of 21, a signature is required below.

DATED: _____

ATELIER HEALTH:

RESPONSIBLE PARTY/PATIENT:

Signature: _____

Signature: _____

Printed Name: _____

Printed Name: _____



ATELIER HEALTH

CARDIOVASCULAR MEDICINE | INTERNAL MEDICINE

AUTHORIZATION FORM

Name on card: _____

Card number: _____ Expiration date: _____

CVV: _____

Card type: Visa Master Card AMEX

Check number: _____

Effective Period: _____

I authorize Atelier Health to charge my credit card for the following:

DESCRIPTION	PRICE
Annual Fee	
Annual Fee for PCP & Cardiology	\$1,800



ATELIER HEALTH

CARDIOVASCULAR MEDICINE | INTERNAL MEDICINE

Name (print)

Signature

Date