GLAUCOMA
CENTER OF
SAN FRANCISCO

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Andrew G. Iwach, M.D.
Shan C. Lin, M.D.
Terri Pickering, M.D.
Sunita Radhakrishnan, M.D.
Sophia Hsiao, O.D.

Emeritus
H. Dunbar Hoskins, Jr., M.D.
Robert N. Shaffer, M.D., *1912-2007*
John Hetherington, Jr., M.D., *1930-2020*

PROMISE TO PAY AGREEMENT

Date: ______________________________________

Patient: ______________________________________

Responsible Party: ____________________________

This payment promise is free of interest and billing charges. This payment promise becomes null and void in the event that I do not pay on the promised date.

If the promise is broken, this option will not be available to me in the future and I will be held responsible for all balances as soon as they become open.

Patient Balance as of the above date: $____________

I will be making a full payment in the amount of $____________ no later than 2 weeks after the signed date of this notice.

I, _________________________, have reviewed and agree to the above payment agreement.

_____________________________________ ____________________________
Signature Date

_____________________________________ ____________________________
Witness Signature Date

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PAYMENT PLAN AGREEMENT

Date: ____

Patient: ______________________________________

Responsible Party: ______________________________

This payment plan is free of interest and billing charges. This payment promise becomes null and void in the event any of my payments become 30 days overdue and the Glaucoma Center of San Francisco will forward the account to a collection agency.

Patient Balance as of the above date: $_____________

I agree to make monthly payments to Glaucoma Center of San Francisco in the amount of $_____________. The first payment is due on or before the _______ day of ______________, 20____ and a like payment is due on or before the same day of each payment period until the balance and all fees due on the balance are paid in full.

I understand that I am responsible for any charges not covered by insurance or other third-party payers. In the event collection or legal action is required to collect this balance, I agree to pay all associated fees within the maximum allowed by law.

I, __________________________, have reviewed and agree to the above payment agreement.

____ ____________________________

Signature Date

____ ____________________________

Witness Signature Date