6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

FINANCIAL POLICY & CONSENT FOR TREATMENT

We are committed to providing you with high-quality medical care and transparent communication regarding your financial responsibilities.

Please review the following policies carefully and sign below to acknowledge your understanding and consent.

CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to receive medical evaluation and treatment from Moukdad Medical and its healthcare providers.

This includes routine diagnostic procedures, physical examinations, and any medically necessary services ordered by my provider.

I understand that I may withdraw this consent at any time by notifying Moukdad Medical in writing.

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Moukdad Medical to release any medical information necessary to process my insurance claims and coordinate care.

I authorize my insurance company, Medicare or any third-party payer to release information as needed for claim processing.

I hereby assign and authorize direct payment of medical benefits to **Moukdad Medical** for services rendered.

I understand that:

> I am financially responsible for any balance not covered by insurance, including co-pays, deductibles, and non-covered services.
>
> If my insurance carrier issues payment directly to me, I will promptly remit that payment to Moukdad Medical.
>
> I am responsible for verifying that my insurance coverage is active and current at the time of service.
>
> It is my responsibility to provide accurate insurance information and to notify Moukdad Medical of any changes.

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CO-PAYS, DEDUCTIBLES, AND BALANCES

Co-pays are due **at the time of service.**

Balances not paid within 30 days of the first statement may be subject to additional billing fees.

If you are uninsured, full payment is expected at the time of service unless prior arrangements are made.

NO-SHOW AND CANCELLATION POLICY

We kindly request **at least 24 hours' notice** for appointment cancellations.

Repeated no-shows or late cancellations may result in a missed appointment fee and/or discharge from the practice.

COMMUNICATION & BILLING NOTICES

You may receive calls, emails, texts or mailed statements related to appointments or billing.

By signing below, you consent to these communications for routine business purposes.

Moukdad Medical will never share your contact information for marketing purposes.

TELEHEALTH SERVICES

I understand that telehealth involves the use of secure electronic communication to provide medical services and consent to participate if recommended by my provider.

PATIENT ACKNOWLEDGMENT

I have read and understand the financial, treatment, and insurance policies of Moukdad Medical.

I understand that I am responsible for payment of all services rendered and agree to comply with these policies.

This authorization will remain in effect until revoked in writing.

Patient Name: _____ **Date of Birth:** _____

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____