Ziyad H. Mugharbil, M. D., P.A.
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Self Pay Payment Agreement

I, ____ understand that Payment in full is due at the time services are rendered. Cash or Credit Card for the amount of the visit will be collected at discharge (unless prior arrangements have been made). It is my responsibility to ask the Doctor and/or the Nurse in the room if any additional charges will be incurred for the services that they are providing during the course of my visit.

Should my treatment include surgery, the Doctor's surgical fee must be paid in full prior to the date of surgery (unless prior arrangements have been made).

____ ___/___ /___
Patient Signature, or, if Minor, Responsible Party Date

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Office Acceptance By

Revised: 02/20/2006