The TMS Center of NJ
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Financial Responsibility and Financial Agreements

I, _____ acknowledge full financial responsibility for services rendered by The TMS Center of New Jersey/David Sikowitz MD PC. I further guarantee the full and complete payment of all charges for medical care rendered by The TMS Center of New Jersey/David Sikowitz MD PC. This is a guarantee of payment and not merely of collection and I agree to be directly responsible for the payment of all charges. I understand that the payment of charges incurred is due at the time of services unless other definite financial arrangements have been made prior to treatment. I understand that David Sikowitz MD and/or his staff reserves the right to charge a reasonable, cost-based fee for costs related to copying, labor and supplies, telephone transmissions, and postage incurred at my request.

I further understand that The TMS Center of New Jersey/David Sikowitz MD PC may or may not participate in my insurance plan. I acknowledge that I am ultimately responsible for charges incurred. While Dr. Sikowitz's office will make every attempt to settle claims and payment with my insurer, there may be discrepancies that will arise for which I will be financially responsible.

I also recognize that any monies that have been paid to the office by credit card and are subsequently reimbursed to me will be subject to the credit card processing fees that the provider has incurred.

If I am unable to make it to my appointment, I will kindly provide notice to the office 48 hours in advance. If I do not provide adequate notice or fail to attend my appointment, I will be responsible for a $100 no-show charge.

I allow my credit card on file to be automatically charged for any unpaid fees or outstanding balances owed to The TMS Center of New Jersey / David Sikowitz MD PC.

_____
Patient or Patient's Legal Representative Signature

_____
Legal Representative's Name & Relationship

_____ Date