HEALTH SERVICE AGREEMENT

Healthcare Provider/ Facility (hereinafter “Provider”): ______________________________

Patient (hereinafter “Patient”): ____

Service/Product: __________________________________

The Provider agrees to provide ____________________________ service to the Patient for a single, all-inclusive price of $_____________. The service is scheduled to be provided to the patient around ___________________ (date).

Provider agrees to accept the all-inclusive price as payment-in--full and to neither charge nor balance bill the Patient for any additional amount, regardless of reason, unless specified here:

____

This all-inclusive price is the only cost that Patient is responsible to pay for the service except to the extent that one or more services are rendered by a separate, nonaffiliated Provider, such as a facility or lab, and is disclosed here:

____

Other terms or conditions:

____
____

In consideration of above, the parties indicate their agreement by signing below.

Patient Name: ______________________

Signature: _________________________

Date: _____________________________

Provider Name: ____________________________

Signature: _________________________________

Date: ____________________________________