Women's Care of Mid Cities

Date: _____

Patient's name: _____

Date of Birth: _____

Payment Agreement and Terms of Service for Maya Health Care, Mid City Health Care Clinic PLLC & Behavioral Health Clinic

This Payment Agreement is made and entered into by and between Maya Health Care, Mid City Health Care Clinic PLLC & Behavioral Health Clinic and the undersigned patient. This Agreement outlines the terms and conditions of payment for services provided by the Clinic.

1. Clinic Details:

    - o Facility Name: Maya Health Care, Mid City Health Care Clinic PLLC & Behavioral Health Clinic
    - o Providers: Vishnu Maya Upadhyay (Nurse Practitioner), (Triple-Certified Family, Women's Health, and Mental Health)
      Pamela Asghar, M.D. (Medical Doctor)
    - o Services Provided: Women's Health, Men's Health, Primary Care, Preventive Care, and Mental/Behavioral Health Care
    - o Location: 350 WESTPARK WAY STE 223, EULESS, TX 76040-3758,

    United States o Contact Numbers: 469-689-6549, ext. 104 & 817-283-4438

    - o Website: https://mayahealthcareclinic.com/

2. Payment Terms: a. Payment Due Dates: Payment for services rendered at the Clinic is expected upfront at the time of service, unless otherwise agreed upon in writing. If payment is not made at the time of service, the Patient agrees to pay the balance due upon receipt of three statements sent by the Clinic.

b. Billing Statements: The Clinic will send the Patient up to three (3) statements, each 30 days apart, detailing any outstanding balance for services rendered. The Patient

acknowledges that these statements will be sent to the most recent address provided.

c. Late Payment and Collections: If payment is not received after three statements have been

issued, the balance will be sent to a collection's agency for recovery. The Patient agrees to pay all collection fees, including but not limited to, agency fees, attorney fees, and court costs, if applicable.

3. Insurance Information and Liability: If the Patient's insurance provides incorrect or incomplete information, the Patient will be held fully responsible for any unpaid balance. The Clinic is not liable for any discrepancies or issues arising from incorrect insurance details provided by the Patient & Insurance Representative. The Patient agrees to promptly notify the Clinic of any changes to their insurance information.

4. Address and Contact Information Update:

a. Obligation to Update Information: The Patient agrees to update the Clinic with any changes to their address, phone number, or other contact information within three (3) business days of such changes.

b. Responsibility for Non-Receipt of Statements: If the Patient fails to update their contact information within the required time frame and the Clinic sends three (3) statements to the most recent address on file, the Patient will be held responsible for the non-receipt of these statements. The Patient understands that failure to update contact information may not excuse payment obligations.

5. Consent to Send Account to Collections: The Patient acknowledges and agrees that if the balance remains unpaid after the issuance of three (3) statements, the Clinic may, at its sole discretion, send the unpaid balance to a third-party collection's agency for further action. This may negatively affect the Patient's credit score.

6. Responsibility for Payment: The Patient is fully responsible for the payment of services provided, regardless of any third-party insurance or other payment sources. It is the Patient's responsibility to ensure that payments are made in a timely manner, and the Patient understands that non-payment could result in further actions, including the use of a collection agency.

7. Contact Information: The Patient agrees to provide current and accurate contact information (including phone number, mailing address, email address, and Date of Birth) to ensure timely delivery of statements and other communications regarding payments.

8. Disclaimer of Liability: a. Clinic or Doctor's Responsibility: The Patient acknowledges that the Clinic and its medical providers, including Dr. Vishnu Maya Upadhyay, (Nurse Practitioner), and Dr. Pamela Asghar, (M.D)., shall not be held liable or responsible for any issues related to non receipt of statements, delays in payments, or any financial consequences arising from a failure to pay the owed balance. The Clinic and its providers are not responsible for any issues resulting from incorrect contact information or insurance details provided by the Patient & Representative.

b. Missed Communication: The Clinic will not be responsible for any missed or delayed communications (including statements) due to the Patient's failure to update their contact or insurance information within the required time frame. The Clinic is not liable for any misunderstandings, missed payments, insurance issues, or negative consequences arising from such missed communications.

9. Acknowledgement of Agreement: By signing below, the Patient acknowledges that they have read, understood, and agree to the terms outlined in this Payment Agreement. The Patient further agrees to comply with all payment terms and conditions.

Patient's Full Name: _____

Patient's Date of Birth

(DOB):_____

Patient's Signature: _____

Clinic Representative's

Name: _____

Clinic Representative's

Signature: _____

Date: _____