GARY H. GOLDMAN, M.D.
OBSTETRICS & GYNECOLOGY
Print Form
(212) 535-6100
715 Park Avenue, New York, NY 10021

SURGICAL FEES

The following is a statement of the pre-operative fees and payment agreement involved in your planned surgery. Please keep this information handy and bring it with you on the date of your pre-operative visit which is scheduled for:_____.

I, _____, understand that Gary H. Goldman, M.D. has recommended that I undergo the following surgical procedure(s):

_____

_____

_____

I understand the *usual* fee for this procedure is $_____.

A 20% deposit in the amount of $_____ is required on the date of your pre-operative visit, payable by cash, check, Visa, MasterCard or American Express.

I also understand that due to the nature of human illness and surgery that not every surgical finding can be anticipated in advance; thus, I am aware that I may require additional surgical procedures for which I will also be financially responsible.

I understand that I am *personally responsible for these fees* regardless of what my insurance company may designate as "reasonable and customary" or what they may choose to reimburse. I am aware that I may be responsible for deductibles and co-pays not paid by the insurance company.

I understand that Dr. Goldman's fees are for his services only. There may be additional charges related to your surgery such as anesthesia, medications, laboratory studies and hospitalization; these fees are separately billed by the hospital.

I have read the above policy and agree to abide by the terms as outlined.

_____	_____	_____	_____
Patient	Date	Witness	Date

** PLEASE BRING THIS FORM WITH YOU ON THE DATE OF YOUR PRE-OPERATIVE VISIT **