

**W. Hamlin Emory, M.D.**  
**A Medical Corporation**  
2080 Century Park East, Suite #1009  
Los Angeles, CA 90067  
Tel: (310) 277-7711 Fax: (310) 277-7723

**PAYMENT AGREEMENT**

I acknowledge that Dr. Emory does not accept medical insurance. Therefore, I demand the right and I choose to contract directly with *W. Hamlin Emory, MD, a Medical Corporation* in order to participate in his treatment method.

I certify that this agreement supersedes any and all prior agreements that I have with my insurance company or provider group.

I understand that I must create an account with the medical office by submitting a credit card number prior to the scheduling of my next appointment. **I also understand that payment for all medical services is due at the time they are rendered and will be charged to this credit card** (Visa, MC, or AMEX).

Credit card number: \_\_\_\_\_ Exp. \_\_\_\_\_

Name (as it appears on card): \_\_\_\_\_

Card Holder Signature: \_\_\_\_\_

*I hereby acknowledge that I have read, understand, and agree to this PATIENT PAYMENT AGREEMENT with W. Hamlin Emory, MD, a Medical Corporation.*

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NAME (print clearly) \_\_\_\_\_

GUARANTOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

GUARANTOR NAME (print clearly) \_\_\_\_\_

**PLEASE NOTE:** Per office policy, **payment is due at the time services are rendered**  
**Patients must either provide a credit card to keep on file OR pay at the time of their visit**

If the patient is NOT the financially responsible party, that person or institution must provide a credit card on behalf of the patient for the office to keep on file.

A statement (superbill) will be sent to the address on file any time the card is charged.