Self Pay Billing Plan

2201 Murphy Ave
Ste 203
Nashville, TN 37203

615.342.6850
615.342.6854 Fax

Patient: _____

Patient Date of Birth: _____

Patient ID: _____

Referring Physician: _____

Inner Vision
Women's Ultrasound

DATE	DESCRIPTION / Code	TOTAL DUE	PAID
	Balance Due		
REMITTANCE:			
DATE:	AMOUNT PAID:	AMOUNT ENCLOSED:	$

I _____ understand that I am being given a discounted rate for self pay and the terms I have agreed to are payment of half of the total due at the time of service and the balance will be due in full 30 days from the date of service.

Patient Signature: _____ Date: _____

Authorizing Signature: _____ Date: _____