Financial Responsibility

All professional services rendered are charged to the patient and due prior to service. I have requested medical services from Dr. Patrick McDougal, Nurse Practitioner Tiffany Johnson, and affiliates of Atlanta Men's Clinic, LLC on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I understand that Atlanta Men's Clinic does not accept insurance and that fees are due and payable prior to services rendered and I personally agree to pay all such charges in full. I have requested these medical services and take full responsibility for all appointments made to the location of my designation for all treatments prescribed for me by Atlanta Men's Clinic and its affiliates. I understand that there are no returns as all sales are final. In addition to agreeing to ensure a payment for any treatments, I agree that I will not cancel any credit card payment to Atlanta Men's Clinic, or any of its affiliates for the services I have requested. A fax or photocopy of this agreement is to be considered as valid as the original. Patient agrees to pay Monthly Service Fees of $269. Accepted payment methods include all major Credit and Debit Cards, as well as HSA and FSA Cards with Visa or Mastercard official logos.

Patient / Responsible Party Signature: _____ Date:_____

Printed Name of Patient: _____

Type of Credit Card: _____

Name as it Appears on Card: _____

Billing Address: _____

Credit Card Number: _____

Expiration Date: _____ CSV:_____

Please fax the entire completed form to 1-844-350-6954 or scan and email it to contact@atlantamensclinic.com

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