

Shivani Shah, D.O., MPH

Pediatric Neurology & Epilepsy

985 Paulison Avenue
Clifton, NJ 07011
Telephone: 201-890-3253
Fax: 973-773-8553

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 60 days, I also agree to pay a finance charges of 1.5% per month on any balance due, as well as reasonable collection costs, court costs, attorney fees and interest fees accrued with the collection of this account.

Responsible Party: _____

Name of the Patient: _____

NOTICE DATED 11/1/2026

Re: **\$50 Fee for missed appointments**

There has been significant increase in missed appointments, in spite of the staff calling patients 24-72 hours prior to the scheduled appointment. When patients do not show for their appointment without calling, it creates empty spots where we could have treated another patient. We will be instituting a \$50 dollar fee for a missed appointment which will have to be paid at the next visit.

I acknowledge receipt of this notice:

Signature: _____

Date: _____