FINANCIAL AGREEMENT

Please read the following and sign in the box provided below.

All professional services provided are charged to the patient unless there is an agreement with a third party payor. Patients are personally responsible for payments of co-payments, co-insurance amounts, deductibles, percentage shares of charges for services rendered, and/or all charges incurred if insurance coverage terminates or changes during the course of treatment. All co-payments must be paid at the time of service. **If your check is returned, bank charges of $25 will be added to your account.**

IF YOU ARE QUOTED THE INCORRECT CO-PAYMENT AMOUNT, YOU WILL BE REQUIRED TO MAKE UP ANY DIFFERENCE AS INDICATED BY YOUR HEALTH PLAN OR THIRD PARTY PAYOR EXPLANATION OF BENEFITS.

MY INSURANCE COMPANY DOES NOT PAY FOR MISSED APPOINTMENTS. I WILL BE BILLED AT THE FULL AMOUNT ALLOWABLE FOR MISSED APPOINTMENTS IF I FAIL TO GIVE 48 HOURS ADVANCE NOTICE. I AGREE TO PAY THIS AMOUNT IN THE EVENT THAT I MISS AN APPOINTMENT OR FAIL TO CANCEL 48 HOURS PRIOR TO THE SCHEDULED APPOINTMENT. APPOINTMENTS FOLLOWING A WEEKEND OR HOLIDAY MUST BE CANCELLED BY NOON THE PRECEDING WORKDAY.

In the event collection or legal action should become necessary to collect any unpaid balance due for services rendered to me and my family, I agree to pay for collection, attorney, and court costs.

A copy of this agreement is as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**

_____

Patients Printed Name

_____

Patient's SS#