

# **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.

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**Patient/Responsible Party Signature**

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**Date**

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**Patients Printed Name**

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**Patient's SS#**