Financial Agreement

We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this practice for you, the patient.

I acknowledge that this office, as a courtesy, will file with my insurance company for its portion of the fees incurred the date of my visit. I know that this office cannot negotiate with my insurance carrier as my policy is a contract between me, my employer, and the insurance company.

I understand and agree that I am responsible for any unpaid balance and will pay in full within **30** days after my insurance company has paid its portion. This includes any dependents for whom I am also responsible.

I have been advised that my account will be referred to a collection agency if the past due balance exceeds **90** days. Notice of this referral constitutes notice of intent to discontinue routine treatment and will automatically release this office of any future professional services to me until my account is resolved. The office has also informed me that there will be a $25.00 service charge on any returned check.

My portion of fees for procedures performed are due upon completion (regardless of insurance coverage) unless prior arrangements have been made. Such arrangements must be in writing. Notifying this office of any change in my insurance coverage is my responsibility.

I authorize this office to submit claims for payment for services to my insurance company, on my behalf and in my name, and assign such provider the group insurance benefits otherwise payable to me.

I understand that I am financially responsible for any balances not satisfied by my insurance carrier regardless of the basis for their nonpayment.

* All major credit cards accepted.

* **We reserve the right to charge a $50.00 fee for broken or cancelled appointments with less than 24 hours notice.**

Signature_____ Date_____