AGREEMENT TO PAY FOR TREATMENT

Please read and sign below. Note; information you provide here is protected as confidential information.

If the patient is insured with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable deductibles and co-payments which may arise during the course of treatment for the patient. All co-pays are expected to be paid at the time of service. The responsible party is also required to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers. We will gladly discuss your proposed treatment and answer any questions that you may have relating to your insurance. You however, must be aware that:

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

Most insurance companies have a yearly deductible that is your responsibility to pay.

Most insurance companies only pay a percentage of the cost (such as 50% or 80% and you will be responsible for the remainder on the date of service.)

Not all services are a covered benefit in all contacts. It is important for you to contact your insurance provider and ask if there are any clauses, or waiting periods.

As a courtesy to you, our office will submit primary and secondary claims to your insurance provider. If, for any reason the claims go unpaid, your will be responsible for all charges.

Bad Check Policy- All checks returned to our office for insufficient funds will be retrieved through electronic payment systems. There will be a $30.00 fee to the patient for this recovery service.

Collection Policy- If we are forced to send a patient to collections for failure to make payment, or if patient declares bankruptcy; they will be expected to pay all charges in advance for any future appointments. If a patient is sent to collections a second time, they and their financial dependents will be dismissed from the practice.

A MINUMUM OF 24-HOURS NOTICE IS REQUIRED TO CANCEL/POSTPONE AN APPOINTMENT OTHERWISE A $45.00 FEE WILL BE INCURRED.

I _____ AM FINANCIALLY RESPONSIABLE FOR ANY AND ALL CHARGES ON MY ACCOUNT AND REALIZE THAT IF I DO NOT PAY MY BALANCE IN FULL AFTER 90 DAYS WITH PRIOR ARRAGNGEMENT, I WILL BE SENT TO A COLLECTION AGENCY WHICH WILL DAMAGE MY CREDIT. PLEASE SIGN AND DATE BELOW IF YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION.

First: _____ Last: _____ _____

PRINTED NAME Date

_____

SIGNED NAME