

10. Financial Policy

Please initial each line:

_____ I agree to pay a \$35.00 fee on all returned or cancelled checks.

_____ I understand payment in full or the estimated insurance co-payment is expected on or before the day treatment is rendered. If not, a signed financial arrangement must be made.

_____ I understand we offer a bookkeepers discount only if full payment is made prior to day of appointment (5% cash or check and 2.5% by credit card). No discounts will apply to payments made on day of service.

_____ I agree to pay 1.5% per month (18% annual) on any unpaid balance past due 60 days.

_____ I understand there is a No Show/Cancellation fee for all appointments. The fee is determined by the amount of time reserved for the visit (\$25-\$500). If unsure about your schedule, wait to make the appointment.

_____ In the event it becomes necessary to make monthly payments, I agree to pay a \$25.00 fee for any month I miss the agreed upon payment, in addition to the finance charges.

_____ I agree that failure to make a payment or to contact us for two consecutive months will result in my account being referred to our collection attorney. All payment arrangements must then be made with them. All collection fees will be added in.

_____ In the event my account is not paid as agreed, I agree to pay a collection fee of 40% of my outstanding balance in addition to my balance. Additional collection agency fees, attorney's fees and court costs will also be added.

_____ If unsure about the cost of treatment, my insurance coverage or my payment options, please ask to speak with the financial coordinator prior to beginning treatment. Once treatment is rendered, I agree and understand I am responsible for all charges.

Patient's name

Date

Patient or Responsible party signature

Date

Witness signature (*team member*)

Date