FINANCIAL POLICY AGREEMENT

Our financial policy is to receive payment in full by the time treatment is completed. If you have insurance, your estimated co-payment of non-covered responsibility will be required at the time of service. You will be billed for any remaining balance that is not paid by your insurance. Any account over 90 days delinquent will be turned over to a collection agency. If this account is assigned to an outside agency for collection, I, We agree to pay all attorney fees, court costs, and a collection charge of 50% which will be added to the outstanding balance of my account.

Signature_____

Please Print Name_____

Date_____Relationship to Patient_____

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