

In order to establish optimal relations with our patients and avoid any misunderstanding regarding our policies, our staff is trained to inform you of the financial policies of the office. **Payment is expected from you at the same of service for "your part" of the charges. Any unpaid balance after insurance claims are filed will be billed to responsible party.** We accept most credit cards for your convenience. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You here in authorized payment of medical benefits to the Doctor when an assigned claim is filed.

By signing below you further agree that if you are more than thirty (30) days late in payment of any bill connected with this treatment, and post treatment, **a finance charge of 1.5% will accrue on the unpaid balance;** and if delinquent account is referred to an attorney or collection agency, I agree to pay the attorney's fees, court costs, and collection agency fees associated with the collection process. I understand that any lab charges (including pathology services performed by my physician) are separate from the charges for my medical care. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments.

In order to provide the best possible service and availability to all our patients, it is our policy to **charge a missed appointment fee of 25.00** for any appointment missed , not canceled or rescheduled. Please call as early as possible if you know you will need to reschedule your appointment.

Signature

Date