

Financial Agreement

Please read this agreement carefully.
We will be happy to answer any questions you may have.

I, _____ (client), understand that my insurance is an agreement between the insurance company and myself.

I understand that _____ (health care provider), will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance company.

I assign payments to be made on my behalf to this provider for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the sixty-first (61st) day.

In the event my insurance company does not pay in full for services provided, I hereby authorize the health care provider to charge all past due payments to my credit card listed below.

In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I _____ (client), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

Signature: _____ Date: _____

Credit Card Number: _____ Expiration Date: _____

Name of Cardholder as it Appears on Credit Card: _____