PATIENT INFORMATION

Name: _____ Birthdate:_____ Soc Sec#:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

If student, name of college:_____ City:_____ State:____

If employed, name of employer:_____ City:_____ State:____ Phone:_____

If spouse employed, name of employer:_____ City:_____ State:____ Phone:_____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____

Person financially responsible for this acct: _____Relationship to patient_____

Address if different from above _____Home Phone_____

State _____ Birthdate _____SS#_____Name of Employer _____

Home Phone _____Cell Phone_____ Work Phone_____

FINANCIAL POLICY

MISSED APPOINTMENTS

Unless cancelled or rescheduled at least 24 hours in advance, our policy is to charge $80.00 for missed appointments. This fee must be paid before another appointment can be scheduled.

REGARDING INSURANCE:

If you have insurance, we require your estimated portion to be paid at the time of service. It is your responsibility to pay the remaining balance not covered by your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, or all of the services provided may be considered a non-covered procedure by your insurance company. If there is no insurance involved, payment is due when services are rendered.

FINANCIAL RESPONSIBLE PARTY:

I hereby agree to the following terms and conditions:
There is a 1.5% monthly late charge assessed on all balances after 60 days past due. A $10.00 late fee will be applied monthly on all balances after 90 days past due. Checks, which are declared non-sufficient funds, will be charged a $25 service fee. Also, the undersign agrees to pay all collection costs, all attorney fees and court cost incurred by the creditor in an amount not to exceed fifty percent (50%) of the total owed when sent to collection.

I have read and understand the above financial policy.

_____ _____

Signature of patient or responsible party Date