

**FINANCIAL AGREEMENT**

- \* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- \* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- \* If sent to collections, I agree to pay all related fees and court costs.
- \* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- \* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- \* I will pay a \$50 fee for appointments broken without 24 hours notice.
- \* Treatment plans may change, and I will be responsible for the work actually done.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF PRIVACY POLICIES**

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature: \_\_\_\_\_ Date \_\_\_\_\_