Notice of Insurance/Account Payment Policy

I authorize the health care provider to submit claims for payment of services to the health care service plans or insurance companies named, on my behalf and in my name. I understand that I am financially responsible for any other charges.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that insurance coverage is only an estimation, and I am responsible for all treatment not covered by insurance. I understand that payment is due at the time of services unless other arrangements have been made prior to my appointment(s). In the event payments are not received by agreed upon dates. I understand that a finance charge may be added to my account. I further understand that I am responsible for attorney's fee and costs of collection in the event of default.

_____ _____

Patient/Guarantor Signature DATE