

## **Financial Agreement**

**As a courtesy, we are willing to assist you in billing your assigned medical charges from this office. You as a patient, are nevertheless responsible for the cost of your treatment.**

**No one at this office can guarantee what your insurance company will pay. We attempt to obtain information regarding general insurance coverage of services, but the best indicator of available coverage is your insurance policy itself.**

**We ask that you pay the cash price at the time of your visit until the deductible is met. After the deductible has been met, you may be required to make a minimal co-pay at the time of each visit. We will bill your insurance company for your visits and await payment for a maximum of 90 days. It may be necessary for you to assist in collecting fees from your insurance carrier. If they refuse to cover your treatment you are responsible for the balance on your account.**

**We hope that this answers most of your questions. If you need further explanation, please let us know.**

**I accept the above terms as binding.**

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**Patient signature**

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**Date**

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**Responsible party**

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**Date**