_____

Name: First, Middle, Last

FINANCIAL ARRANGEMENT

Treatment and the proposed insurance coverage have been explained to me. I_____ UNDERSTAND THAT NOTHING IS GUARANTEED FROM THE INSURANCE COMPANY UNTIL FINAL PAYMENT IS RECEIVED. In the event that the insurance carrier should fail to make the indicated payment for service, patient is responsible for any and all charges declined by their carrier.

I AGREE THAT THE REMAINING BALANCE NOT COVERED BY INSURANCE OF _____, WILL BE PAID IN ___ INSTALLMENTS OF _____.

THE BALANCE TO BE PAID IN FULL WITHIN THE NEXT ___ WEEKS. DATES ARE AS FOLLOWS:

_____

IN THE EVENT THAT PAYMENTS ARE NOT RECEIVED IN THE AGREED UPON TIME FRAME OR THE INSURANCE FAILS TO MAKE PAYMENT FOR ANY REASON., I MAKE PAYMENTS ACCORDINGLY USING THE CREDIT CARD INDICATED BELOW.

SIGNED: _____

DATE: _____

CREDIT CARD_____
EXP DATE:__/__ CODE:_____