



PLEASE READ CAREFULLY PATIENT-DOCTOR AGREEMENT

Missed/Changing Appointments

- * We schedule appointments according to urgency and availability.
- * In order to receive the maximum benefit from care; it is important to adhere to this schedule. Please arrive at, or just before, your appointment time.
- * If you find that you are running late, please call our office to determine if we can hold your appointment.
- * If for any reason you are unable to keep your scheduled appointment, you must give our office 24 hour notice or you will be charged a \$45.00 service fee.
- * Patients with Medical Assistance that miss more than 3 appointments without cancellation will be discharged from this practice.

_____ Initial

Insurance Authorization and Assignment of Benefits

- * I authorize and request that insurance payments be made directly to this office and any medical payment from the patient's insurance for services rendered.
- * Patient understands that if she/he suspends or terminates care, any fees for services rendered to patient will be immediately due and payable.

_____ Initial

Payment Policy

- * I acknowledge full financial responsibility for services rendered and I understand payment for services are due on the day of service.
- * This includes co-payments and payment for medical forms (\$10.00 fee).
- * Any balance that is left unpaid for over two billing cycles is subject to a \$10.00 late fee.
- * This late fee will be applied to any unpaid amount.
- * If a check has been written for payment and the check is returned for insufficient funds, there will be a \$25.00 fee added to your current balance.

_____ Initial

Communication

We are here to serve you. Please speak to us about any concerns that may arise at any time. By communicating how you are experience care in our office, you enable us to provide you with the best care possible. Thank you!

By signing below, I indicated that I have read the above policies and agree to the applicable conditions. I consent treatment, financial responsibility and insurance authorization.

Parent Printed Name

Parent Signature Date

Date