Financial Agreement Form

I agree that in return for services provided to the patient by the Medical Practice, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Medical Practice for payment. If an account is sent to an attorney or a collection agency, I agree to pay collection expenses of up to $50 or 20% of the total balance, whichever is greater. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Medical Practice.

Patient Signature:

Patient Name: _____

Date: _____