# INSURANCE/FINANCIAL POLICIES

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| PRIMARY INSURANCE _____ | SECONDARY INSURANCE _____ |
| INSURANCE COMPANY NAME _____ | INSURANCE COMPANY NAME _____ |
| INSURED _____ | INSURED _____ |
| GROUP NUMBER _____ | GROUP NUMBER _____ |
| MEMBER ID _____ | MEMBER ID _____ |
| CLAIMS ADDRESS _____ | CLAIMS ADDRESS _____ |
| CITY _____ | CITY _____ |
| STATE _____ ZIP CODE _____ | STATE _____ ZIP CODE _____ |
| INSURANCE PHONE _____ | INSURANCE PHONE _____ |

PAYMENT PLANS WILL BE BASED UPON THE PRIMARY INSURANCE PAYMENT. SECONDARY INSURANCE WILL BE SUBMITTED WHEN PAYMENT OBLIGATION IS COMPLETED BY PRIMARY INSURANCE CARRIER AND PATIENT.

STATEMENTS ARE MAILED EACH MONTH. PAYMENTS NEED TO BE RECEIVED BY THE DUE DATE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

ANY CHECKS RETURNED WILL BE CHARGED A $25.00 SERVICE FEE.

WE REQUIRE 24 HOUR NOTICE FOR ANY CHANGES OR CANCELLATIONS TO YOUR APPOINTMENT OR YOUR ACCOUNT MAY BE ASSESSED A FEE.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

IN THE EVENT PAYMENTS ARE NOT RECEIVED BY AGREED UPON DATES, I UNDERSTAND THAT 1½% / MONTH LATE CHARGE (18%APR) WILL BE ADDED TO MY ACCOUNT.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to patient _____