COLLECTION POLICY

Patient Name: ____

I, __________________________________ hereby, agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that will be added in the amount of 53.84% to pay for the collection fees of 35% that will be charged by our collection agency.

Returned checks: A $25.00 NFS fee will be charged for check initially returned unpaid by your bank, if the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

____
Signature Patient or Responsible Party

Date____/____/____

____
Signature Witness

Date____/____/____