

## **FINANCIAL POLICY**

- I understand that payment is expected at the time of service unless prior arrangements have been made.
- I understand that a billing charge will be added to my unpaid account each time a statement is sent.
- I understand that any fees associated with the collection of this account will be my responsibility.

Patient Name(printed)\_\_\_\_\_

Patient Name(signed)\_\_\_\_\_

Date\_\_\_\_\_

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