Client Financial Agreement

Dear Client,

This letter sets forth our office financial payment policy.

I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of services, as set forth by my consent to treatment. I understand that a fee is charges for all visits, examinations, or medical reports. I understand that I have the primary duty and obligation to pay my therapist for services, notwithstanding ant contract I may have with any third-party payer (for example, insurance company, employer, etc.)

I have been informed that if I choose to use insurance, the insurance company may send payment for services in the form of a check made payable to myself. At which time I agree to sign the check over to Romantic Restoration LLC., for services rendered.

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and / or dependents.

I hereby authorize my insurance company to pay and hereby assign directly to Romantic Restoration LLC. All benefits. I further acknowledge that any insurance benefits when received by and paid will be credited to my account, in accordance with my insurance company’s assignment. Any unpaid charges are my responsibility.

Should I fail to pay unpaid charges for more than 30 days, I authorize unpaid charges to be charged to the credit card provided below. Unpaid charges over 60 days will incur a monthly service fee of $25. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill.

If a credit card is not presented to the practice, a deposit of $100.00 is required, to be applied to any and all unpaid client balances. This deposit will also be credited to any fees sustained due to a no show or late cancellations. There is a $25.00 service charge for a returned check. Should my insurance cover all services, the money will be refunded upon final insurance payment.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing Romantic Restoration LLC with complete and accurate billing information, including, but not limited to, a current insurance card, and proper identification.
2. I will pay all applicable co-pays and outstanding balances as they become due. All co-pays and balances are due at each visit.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED (client or guarantor) Date:

FOR (print client name)