Financial Responsibility

Patient Name: _____

I hereby agree to be financially responsible for all charges, regardless of insurance coverage. If my account is referred to a collection service due to lack of payment, I agree that all collection/legal fees may be added.

Returned checks: A $25.00 NSF fee for checks initially returned to the bank will be charged. If the check is returned unpaid a second time, it may be referred to a collection agency for recovery. '

Patient signature or responsible party _____

Date _____

Signature of witness·_____

Date_____

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