Cary Healthcare Associates, P.A.

OFFICE POLICIES

FINANCIAL AGREEMENTS

I understand that I am financially responsible for ALL charges incurred at Cary Healthcare Associates regardless of third party liability (insurance carrier).

If your insurance requires that you pay a co-pay, deductible or co-insurance you are responsible for full payment at the time of the service.

If you have no insurance, you will be required to pay in full at the time of service.

I understand that I will receive 3 statements (1 each month) for any outstanding balances, and then will be placed into collections. A $20.00 "Collection Fee" will be added to my account to cover the fees imposed to Cary Healthcare Associates by the collection agency.

CANCELLATION POLICY

I understand that a 24 hour notice is required to cancel an appointment. A **$50.00** fee will be charged when an appointment is missed without a 24 hour notice on the 1st occurrence, **$100** on the 2nd occurrence, and **$150** for any subsequent visits for the calendar year.

CARY HEALTHCARE ASSOCIATES RESERVES THE RIGHT TO DISMISS FROM THE PRACTICE ANY PATIENTS WHO FREQUENTLY MISS SCHEDULED APPOINTMENTS.

I have read and understand the above office policies and agree to accept responsibility as described.

Patient's Signature: _____ Date: _____

Signature of Personal Representative: _____ Date: _____