Cary Healthcare Associates, P.A.

OFFICE POLICIES

FINANCIAL AGREEMENTS

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED AT CARY HEALTHCARE ASSOCIATES. IF YOUR INSURANCE REQUIRES THAT YOU PAY A CO-PAY, DEDUCTIBLE, OR CO-INSURANCE YOU ARE RESPONSIBLE FOR FULL PAYMENT AT TIME OF THE SERVICE.

IF YOU HAVE NO INSURANCE YOU WILL BE REQUIRED TO PAY IN FULL AT TIME OF SERVICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES INCURRED AT CARY HEALTHCARE ASSOCIATES REGARDLESS OF THIRD PARTY LIABILITY. (INSURANCE CARRIER)

CANCELLATION POLICY

I UNDERSTAND THAT A 24 HOURS NOTICE IS REQUIRED TO CANCEL APPOINTMENTS. PLEASE BE NOTIFIED THAT 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: _____