Financial Agreement

Patient Name: _____

For my convenience, Dr. Aeschliman and his staff may release my information to my insurance company and receive payment directly from them.

+ Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible for the total charges. We are in network with Cigna, Delta and Guardian.
+ I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
+ I understand that if I arrive to my appointment late by 15 minutes or more, my appointment will be rescheduled and I will still receive a 10% fee of scheduled treatment.
+ I will pay a fee for appointments broken without 48 hours notice of 10% of the scheduled treatment.
+ I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
+ If sent to collections, I agree to pay all related fees and court costs.

_____
Signature of Patient or Parent/Guardian

_____
Date